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AIDS

No Time for Complacency



World Health Organization
Regional Office for South-East Asia
New Delhi
1997

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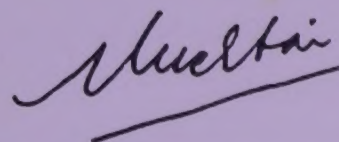
Foreword

The first edition of the book "AIDS in South-East Asia: No Time for Complacency" was published in 1992 and provided basic information related to the AIDS epidemic in South-East Asia. Since then, over 20,000 copies have been printed and distributed to a wide range of individuals and organizations representing media, health, social work, education and other fields, from both government and non-government sectors in the Region.

It is hoped that this revised and updated version will not only further enhance AIDS awareness in the Region but will also stimulate people to take action to prevent the spread of HIV infection and to develop compassion and care for those living with HIV/AIDS.

The relentless spread of AIDS in the past few years has unfolded its grave health and socioeconomic consequences. What is very clear is that the Human Immunodeficiency Virus (HIV) which causes AIDS knows no boundaries. All communities and sections of society are vulnerable. No one is immune.

The situation in South-East Asia, with over 65,000 reported AIDS cases and over 3.7 million people estimated to be infected with HIV, is extremely alarming, and certainly leaves no room for complacency.



Dr Uton Muchtar Rafei
Regional Director

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The revised edition is the result of an extensive review of the earlier edition carried out by the staff and consultants of the STD/AIDS Unit of WHO's Regional Office for South-East Asia – Dr A.R. Soerono, Dr G.N. Jayakuru, Dr Clement Chela, Dr Saroj Jha and Dr J.P. Narain.

Additional information as well as updates of relevant data now included in the revised edition have been made through their valuable contributions. Acknowledgement is also given to Dr H. Honna Bovi for reviewing and contributing to the substance of the book. The secretarial assistance provided by Ms Shirley Kishanchand and Mr Govind Kapoor are gratefully acknowledged.

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The Story So Far

AIDS — the acronym for the Acquired Immune Deficiency Syndrome evokes a response of familiarity today. Fifteen years ago, this was not so. In the summer of 1981, the Centers for Disease Control (CDC) in the United States reported that five previously healthy homosexual men in Los Angeles were suffering from an unusual type of pneumonia caused by *Pneumocystis carinii*, a parasite which is normally harmless to humans. CDC also reported that 26 previously healthy homosexual men in New York and Los Angeles had developed a rare form of skin cancer called Kaposi's Sarcoma. These reports signalled the arrival of a mysterious acquired disorder of the human immune system which disabled the body's defences. This was the beginning of one of the biggest public health and developmental problems of this century, which started from mere smoke signals and swept across the globe like wildfire.

Although homosexual men from the United States and other developed countries were the first reported cases of AIDS worldwide, the picture rapidly changed into that of a global epidemic (pandemic). AIDS was being reported in men, women and children from all over the world. By early 1989, more than 140 000 AIDS cases had been officially reported to WHO from around the world. By May 1997,

this figure had skyrocketed to 1 544 067 cases of AIDS. Of these, 749 800 were in the American region and 553 291 in the African region. In South-East Asia 65 083 AIDS cases have been reported by 1 May 1997. Nevertheless, taking into account the delays in reporting, under-diagnosis and under-reporting, WHO estimates that over 8 million people in the world have already developed AIDS and a vast majority of these have died. AIDS is now the leading cause of death among adults in sub-Saharan Africa and among young adults between 15-24 years in the USA. Globally, 26.8 million adults (about 15-16 million men and 11-12 million women) and over 2.5 million children have been infected by the human immunodeficiency virus – the virus that causes AIDS. Three-fourths of all HIV infections today are due to heterosexual transmission. According to one estimate, more than 7000 people may become infected with HIV every day.

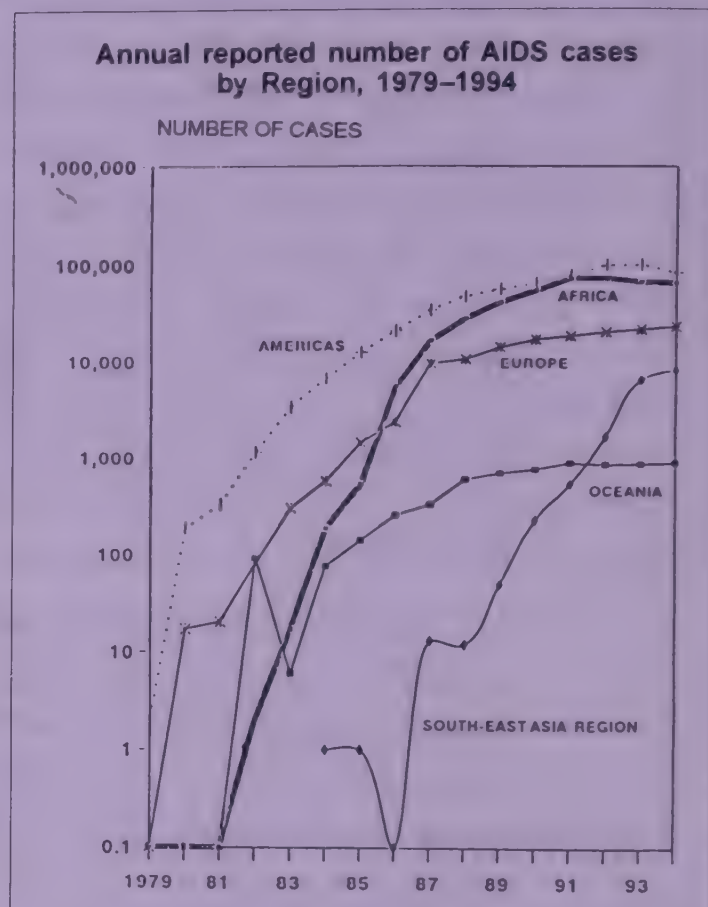
- Although HIV came later to South-East Asia, it is spreading at an alarming rate.
- WHO estimates that in South-East Asia more than 3.7 million adults are already infected with HIV. More than 65 000 AIDS cases have so far been reported, over 85% of which have been reported after 1993.
- By the Year 2000, WHO estimates that between 8 and 10 million men, women and children in Asia will have been infected with HIV.
- The rapidly expanding epidemic will lead to excess morbidity and premature mortality particularly among the most productive age groups of society.
- The demand for care and treatment will soon place extreme pressure on the health services.

AIDS came later to WHO's South-East Asia Region. The first reported case was in Thailand in 1984. According to the available data, over 65 000 cases of AIDS had been reported from the countries of the Region by 1 May 1997. Thailand and India have reported the largest number (95%) of cases. Bhutan and DPR Korea are yet to report a case. Compared with other WHO regions, these figures may seem small, but there is no room for complacency. Of all the AIDS cases reported in the region so far, more than 85% have occurred since 1993. Although the incidence of AIDS in this region is still in its early stages, the virus is spreading very rapidly and more than 3.7 million adults are estimated to have been infected.

Marginalized groups in the population are particularly vulnerable to HIV infection. The exceptional increase of HIV infection in female commercial sex workers in Thailand and India, and injecting drug users (IDUs) in Thailand, India and Myanmar, are cases in point. In Thailand, HIV rates among IDUs increased sharply from about 1% at the beginning of 1988 to 39% by mid-1989. In Myanmar, the HIV rates among IDUs was zero in 1988; by 1991 it had risen to 71%. Similarly in Manipur, in India's north-eastern region, HIV infection increased from 1% to 56% between 1988 and 1995 among IDUs tested for HIV. Presently 37% of IDUs in Thailand, 54% in Myanmar and 56% in Manipur are HIV positive.

Among female commercial sex workers, HIV rates in Vellore (India) increased from 0.5% in 1986 to 34.5% in 1990. In Bombay (India), the corresponding figures increased from about 1% in 1986 to 18% in 1990, and 51% in 1996. In Chiang Mai (Thailand) about 44% of "lower class" female commercial sex workers tested positive for HIV infection in 1989; a year prior to that, only 1% had been infected. HIV infection is also increasing among truck drivers and migrant workers as well as among patients with STDs.

In many countries the virus has now begun to spread into the general population as well. As is happening in some other parts of the world, women are becoming increasingly infected with HIV. HIV infection rates in pregnant women of 8% in Chiang Mai (Thailand), 2.5% in Bombay (India) and 3-7% in parts of Myanmar have been documented recently. The number of children being infected perinatally is also continuously increasing. The number of reported paediatric AIDS cases increased from 2 in 1988



to 853 between 1989 and 1994. It is now estimated that there are more than 2.5 million persons infected with HIV in India, 800 000 in Thailand and nearly 350 000 in Myanmar.

The projections for the future are more grim. WHO projects that by the year 2000, a total of 30 to 40 million men, women and children will have been infected globally with HIV, of which nearly one-fourth will be in Asia. There will be over one million adult cases and deaths globally every year. A majority of these deaths will be in developing countries – about half-a-million in Africa and a quarter of a million in Asia. The scenario also projects that by the year 2000, more Asians than Africans are likely to be infected every year.

The future projections and alarming statistics underline the need for dealing with AIDS in South-East Asia on a war footing!

Socioeconomic Impact of HIV/AIDS

AIDS threatens the very fabric of society. It affects people in their most productive age, resulting in several direct and indirect economic costs. These include increased spending on health care; a drain on health care resources, including hospitals, drugs and staff; loss of production and productivity in all sectors of the economy including women's labour in and outside the home; loss of investment in training of skilled labour and educated professionals; loss of consumers and purchasing power; and loss of tourist revenues. In developing countries, these costs may further affect already troubled and burdened economies. Because AIDS incapacitates people at ages when they are most needed for the support of the young and the elderly, the impact on families with one or more HIV-infected members is enormous, and is aggravated by the frequent stigmatization of people with HIV/AIDS. AIDS will also leave millions of children without parents. These AIDS orphans will swell the ranks of street children, already estimated at over 100 million, increasing the number of young people vulnerable to infection with HIV.

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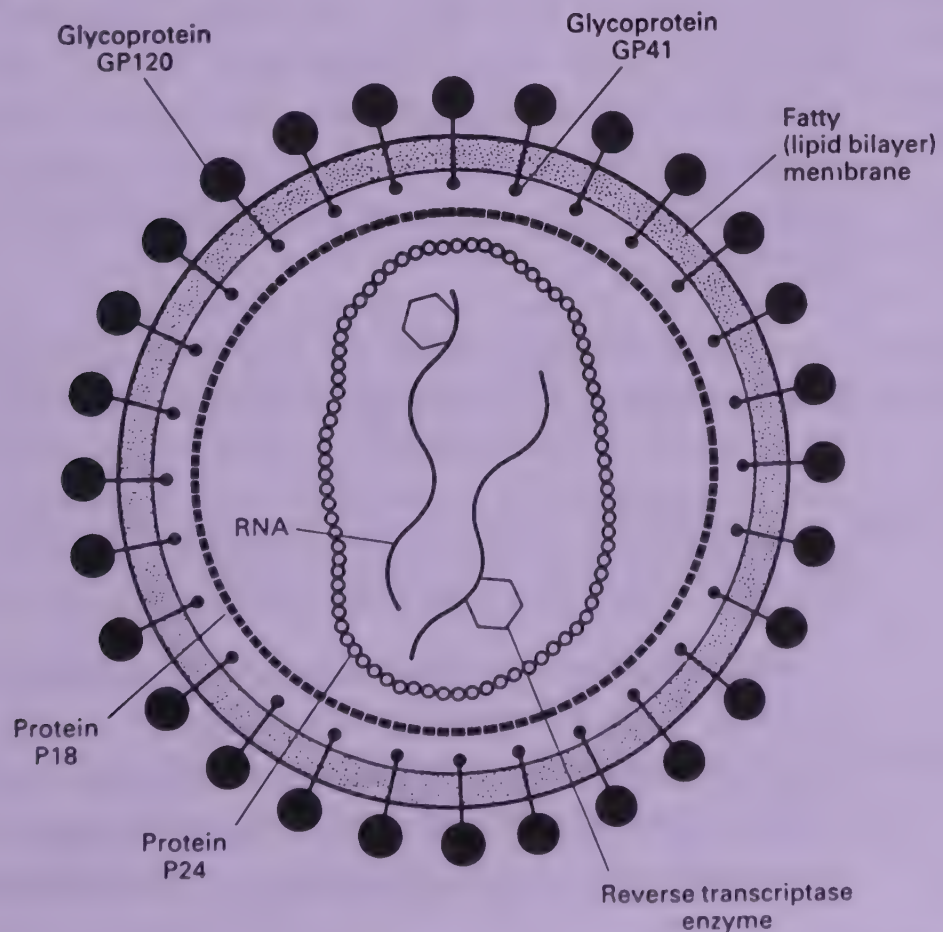
HIV and AIDS – A Dangerous Game of Hide and Seek

AS is evident by its name, AIDS is not a single disease but is a syndrome – a set of diseases, which result from the destruction of the body's defences by the human immunodeficiency virus, HIV. In healthy individuals, infections and cancers are kept at bay by virtue of an array of defenders in the body, which constitute its immune system. Unknown to us, these defenders – the white blood cells – are at work every day, recognizing foreign invaders in the body and fighting them both by recruiting an army of cells which attack infection directly and by producing specific chemicals called antibodies, which neutralize the invaders. Each disease stimulates the production of antibodies specific to it, and in some, like measles, these offer lifelong immunity against that disease. The detection of these antibodies in blood samples is therefore used to determine past or present infection.

How exactly HIV knocks down the immune system is still a matter of active research. According to the most widely accepted theory, HIV zeroes in on white blood cells called lymphocytes, which play a vital role in orchestrating the defences of the immune system. They possess a molecule called CD4 on their surfaces which helps

the immune cells to communicate with each other. HIV, on gaining entry into the CD4 cells, manipulates the cell's genetic apparatus and inserts its own genetic information, turning the cell into a factory that produces several new copies of itself. The brigade of newly-multiplied HIV escapes from the cell by punching holes in the cell membrane thereby destroying it. Out in the bloodstream, the viruses can now infect new CD4 cells.

The strange thing about HIV is the long time it takes to do its damage. After inserting its genetic blueprint into that of the host CD4 cell, HIV may lie 'hidden' for several years before triggering its rapid multiplication and destruction of the cell. This way it escapes being attacked by antibodies which are circulating in the blood to seek out and destroy it. The dangerous game of hide and seek ends when so many of the white blood cells have been destroyed that the body falls prey to opportunistic infections and cancers described as the hallmark of AIDS.



More About HIV -- The Virus That Causes AIDS

Barely two years after the first AIDS case was diagnosed and reported in USA, around mid-1983, Professor Luc Montagnier and his colleagues at the Pasteur Institute in Paris discovered a new virus from the lymph glands of a male homosexual with persistent generalized lymphadenopathy (PGL). They called it lymphadenopathy associated virus (LAV). Shortly afterwards, a team led by Dr Robert Gallo at the National Cancer Institute in Bethesda, USA, also detected the presence of a new virus isolated from patients with AIDS. They called it by a different name though – the human T-lymphocytic virus III (HTLV III). An international committee on taxonomy of viruses achieved a general consensus on its present name – human immunodeficiency virus (HIV).

HIV belongs to a family of viruses known as retroviruses. These viruses defy a general rule of biological systems whereby the genetic commandments flow from the master molecule deoxyribosenucleic acid (DNA) to ribose nucleic acid (RNA), which results in the production of proteins that keep the system working. HIV, like all retroviruses, has an enzyme called 'reverse transcriptase', which actually reverses this genetic hierarchy and enables RNA to direct the synthesis of DNA first.

HIV looks like a rolled up porcupine. It contains two snake-like single strands of RNA along with reverse transcriptase firmly wrapped up in a core which resembles a cone with a dimple at its base. This core is protected by a spherical shell of protein which, in turn, is encapsulated by an envelope which has a knob-like protein sticking out of its surface, giving HIV its characteristic appearance.

On entering the white blood cells known as CD4 cells, HIV sheds its coats to expose its true colours – deadly genetic machinery which masterminds the production of its own DNA and sees to it that this gets inserted into the DNA of the host cell. The viral DNA has enough power and information to direct the destiny of the cell.

It can force the cell to manufacture raw materials which, if it so desires, can give rise to several new copies of HIV. However, due to certain trigger and regulatory mechanisms, the viral DNA lies dormant in the host cell for several years before it begins to do damage. By virtue of its slow action, HIV is classified under a subgroup of retroviruses called lentiviruses (from *lentus* = slow).

We refer to HIV as though it is one virus. In fact, it seems to have changed its structure over time and in different places. Currently, it is best recognized as a family of closely related viruses, the commonest of them being HIV-I. A distinctly different form of HIV is common in West Africa. It is called HIV-II. In South-East Asia, HIV-II has been found in Maharashtra, India, and in two cases reported from Sri Lanka.

It is important to distinguish between being infected with HIV and having AIDS. *People infected with HIV may take 7-10 years to develop AIDS.* In developing countries, the progression to AIDS may be sooner because of malnutrition and a poorer state of health. During this interval, HIV infected individuals may suffer from a variety of disorders and develop signs which are suggestive of being infected with HIV. One of the common signs is the painless swelling of lymph glands in the neck, armpits and groin, called persistent generalized lymphadenopathy (PGL). PGL usually takes 3-5 years to develop after a person is infected with HIV. People with PGL may also suffer from other symptoms such as fever or night sweats, diarrhoea, loss of weight and infections such as thrush (candidiasis) and herpes. This cluster of signs and symptoms was often designated as the AIDS-related complex.

AIDS is diagnosed by demonstrating the presence of one or more opportunistic infections, cancers and other infections like:

- a type of pneumonia called *Pneumocystis carinii*.
- a variety of intestinal infections resulting in diarrhoea and weight loss and known as 'slim' disease in some parts of the world.

- a skin cancer called Kaposi's Sarcoma.
- infections of the nervous system; damage leading to deterioration of intellectual capacity (dementia).

In conjunction with opportunistic infection(s), two more factors are taken into account to confirm a diagnosis of HIV/AIDS. First, the number of CD4 cells in the blood drops to below 200 per microlitre, whereas a normal count is 800 to 1200 per microlitre. Second, it is essential to demonstrate the presence of HIV in the blood using sensitive blood tests, the most widely used being the enzyme-linked immuno-sorbent assay (ELISA) which detects antibodies generated by the body in response to infection by HIV. Antibodies against HIV, however, start appearing in the blood in significant amounts only 6 to 12 weeks after a person has been infected with HIV. If the blood is tested in the period immediately after infection, known as the 'window period', the ELISA test will fail to indicate positivity even though the virus is inside the white blood cells.

The several types of ELISA test use different antigen preparations or different test principles. Depending on the test used, the results are available between twenty minutes and one hour and thirty minutes. The cost varies from 0.06 to 3.00 US dollars per test. The Western Blot test is much more expensive (about US\$ 20) and takes three hours to produce results. Owing to the high cost (prohibitive to many developing countries) and the complexity of performance and evaluation of the Western Blot test, WHO has assessed other rapid/simple tests for confirming the results of the initial ELISA test. Simple or rapid screening tests give quicker results (in 3-6 minutes) and cost less (1.9 to 2.28 US cents). The results of 16 screening tests show that repetition of the screening test with ELISA or other simple rapid tests is at least as accurate as the conventional procedure of confirming the initial screening test by Western Blot. Hence the Western Blot test is no longer recommended as a confirmatory test

except in situations where tests with ELISA are inconclusive or equivocal (borderline).

Since sophisticated methods for counting CD4 cells and carrying out blood tests may not be available in many developing countries, WHO has listed a few signs that help in the provisional diagnosis of AIDS in adults. The presence of at least two major signs associated with at least one minor sign can be an indication of AIDS provided that other causes of depleted immunity, like malnutrition have been ruled out.

The major and minor signs are listed below:

Major Signs

- Weight loss greater than 10% of body weight.
- Fever for longer than one month, intermittent or continuous.
- Chronic diarrhoea for longer than one month, intermittent or constant.

Minor Signs

- Persistent cough for longer than one month.
- General itchy dermatitis (skin irritation).
- Recurrent herpes zoster (shingles).
- Oro-pharyngeal candidiasis (fungus infection in the mouth/throat).
- Chronic progressive and disseminated herpes simplex infection.
- Generalized lymphadenopathy (swelling of lymph glands).

In children, a diagnosis of AIDS is suspected when an infant or child presents with at least two of the following major signs associated

with at least two of the following minor signs, provided other causes, for depleted immunity such as severe malnutrition or cancer have been ruled out.

Major Signs

- Weight loss or abnormally slow growth.
- Chronic diarrhoea > 1 month.
- Prolonged fever > 1 month.

Minor Signs

- Generalized lymphadenopathy.
- Oro-pharyngeal candidiasis.
- Repeated common infections (otitis, pharyngitis, etc).
- Persistent cough.
- Generalized dermatitis.
- Confirmed maternal HIV infection.

So far there is no cure for AIDS, and a vaccine may be far away. Three drugs which may help AIDS patients in prolonging life by a few more years are: (1) zidovudine-AZT, (2) dideoxyinosine (ddI) and (3) dideoxycytidine (ddC). These can only offer temporary relief to patients with AIDS or may delay the onset of AIDS among those with HIV infection. Recently, the newer drugs - protease inhibitors when given in combination with AZT or others show great promise in bringing viral load to very low levels.

These drugs, however, are very expensive and beyond the reach of most people in the region. Moreover, the drugs can cause severe adverse reactions and the chance for development of resistance is high when AZT is used alone. Combination therapy - AZT and ddI or

ddC and newer drugs namely protease inhibitors (such as saquinavir, indinavir and zidovudine) – is much more effective than treatment with one or two drugs and reduces the chance of drug resistance.

Tuberculosis and HIV -- A Deadly Duo

One of the several opportunistic organisms that can attack people with HIV infection is *Mycobacterium tuberculosis* – the bacterium which causes tuberculosis (TB). This bacterium, though present in the bodies of one-third of the world's population, is not able to do any damage in healthy individuals enjoying a normal immune system. In people infected with HIV, however, it is quick to gain an upper hand over the beleaguered immune system and spreads to various parts of the body.

Tuberculosis flourishes where there is poverty, malnutrition, overcrowding and inadequate health care. A parallel epidemic of TB following the AIDS pandemic is already occurring in many developing countries, particularly in sub-Saharan Africa. WHO estimates that more than seven million people, 98% of whom are in the developing world, are co-infected with HIV and TB. In many countries such as Uganda, Zambia, Rwanda and Malawi, the reported number of TB cases more than doubled during the late 1980s. This was primarily attributable to HIV. TB is also emerging as a major problem in the developed world, particularly in the USA, as multi-drug resistant TB (MDR-TB) carrying a higher mortality rate becomes more prevalent.

In South-East Asia, high rates of acquired drug resistance of up to 35% and 46% have been documented in India and Nepal respectively. In this Region, TB exists as a latent infection in nearly one half of the adult population. There are data to show that 40-60% of AIDS patients in India, Myanmar, Nepal and Thailand have TB, indicating that TB is the most common life-threatening opportunistic infection associated with HIV. Moreover, as in Africa, the incidence of TB is

now on the increase in high HIV prevalence areas such as northern Thailand and Bombay in India. The deadly duo of HIV and TB may thus mean an additional drain on meagre health resources. The strengthening of national TB control programmes to ensure that all patients diagnosed with TB are treated effectively is urgently required.

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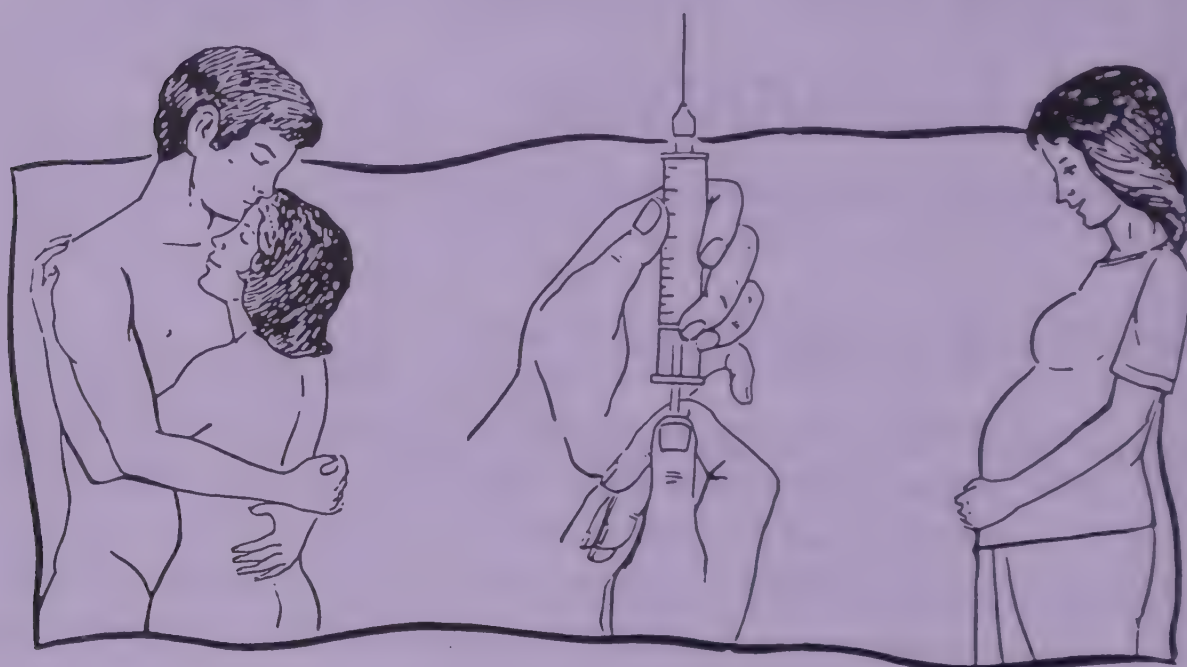
How HIV Spreads — Routes of Transmission

THERE are only three well-defined routes through which HIV can be spread. The most common of these is through sexual intercourse. HIV can spread both through homosexual and heterosexual intercourse when a partner is already infected. Although the probability of transmission of HIV infection through this route is only one in a hundred to one in a thousand, heterosexual contact has emerged as the single largest cause for the spread of HIV in South-East Asia. Women are at greater risk of being infected by their male partners because transmission from male to female is more efficient than from female to male.

In those infected, HIV is found in body fluids like blood, semen, vaginal secretions, tears, saliva and breast milk. However, only blood, semen, vaginal fluids and breast milk have been implicated in the transmission of HIV.

During sexual intercourse, damage to the linings of sexual organs facilitates transmission of HIV from the infected partner to the uninfected one by exchange of body fluids. It is easier for the virus to be transmitted if the uninfected partner is already suffering from some sexually transmitted disease, because in this

case the lining of the organs is already damaged. The risk increases four to six-fold, particularly if the partner has genital ulcer disease such as syphilis, chancroid or herpes. It is also possible that the virus is transmitted to the white blood cells which are normally found in the linings of various openings of the body such as the genital areas. Irritation, infection and damage to these linings spurs on the white



blood cells to rush there in large numbers to repair the damage and offer protection from infection, thereby increasing their concentration locally. This in turn increases the risk of HIV transmission.

Sexually transmitted diseases (STDs) remain a serious public health problem in South-East Asia and rank among the top five diseases in adults who seek health care services. The appearance of HIV and the increase in the number of patients with AIDS, which is basically an STD with high mortality, has focused even greater attention on the control of sexually transmitted diseases, and particularly on the need to treat STDs promptly.

The correlation between HIV and sexually transmitted diseases

- The predominant mode of transmission of both HIV and other STD agents is sexual, although other routes of transmission for both include blood, blood products, donated organs or tissue, and from an infected woman to her foetus or newborn infant.
- Many of the measures for preventing the sexual transmission of HIV and other STD agents are the same, as are the target audiences for these interventions.
- STD clinical services are an important access point for people at high risk of contracting both AIDS and other STDs, not only for diagnosis and treatment but also for education and counselling.
- There is a strong association between the occurrence of HIV infection and the presence of certain STDs, making early diagnosis and effective treatment of such STDs an important strategy for the prevention of HIV transmission.
- Trends in STD incidence and prevalence can be useful early indicators of changes in sexual behaviour and are easier to monitor than trends in HIV seroprevalence.
- In view of the strong association between HIV/AIDS and STDs, programmes to control HIV/AIDS now also focus on STDs control through HIV/AIDS/STD programmes.

HIV Transmission in South-East Asia, 1994	
Route of Transmission	% of Total
Sexual Intercourse	85-90
Blood	
Transfusion	3-5
Injecting Drug Use	3-5
Equipment/Needles	<0.1
Perinatal	<2-5

The second route of HIV transmission is through infected blood and blood products, and through contaminated needles and syringes. Although probability of transmission of HIV infection through infected blood is the highest – more than 90 per cent. The commonest route of transmission is still through sexual intercourse, as there is much more sexual activity going on among people as compared to blood transfusion activity. Before blood tests to screen HIV became available, people with diseases like sickle cell anaemia and haemophilia, which required repeated blood transfusions, acquired HIV infection through contaminated blood. These days, however, this risk can be completely eliminated by routine and mandatory screening of blood samples for HIV. The risk of HIV transmission through sharing of unsterilized needles and syringes by injecting drug users (IDUs), on the other hand, is very high. This may be because blood is commonly sucked back into the syringe and then re-injected. In Myanmar, Thailand and India's north-eastern states, this practice has resulted in a dramatic increase in HIV infection among IDUs. The risk of HIV transmission in health care settings, i.e. from doctor to patient or vice versa, or from patient to patient, is very low – only 0.3 per cent. For example, a health care worker may receive a needle stick injury, thus exposing himself/herself to HIV.

The third route of HIV transmission is from an infected mother to her child during pregnancy, at birth or shortly after birth. The

probability of transmission of HIV infection by this route is about 30 per cent. Although breast milk may also contain HIV in small amounts, breast-feeding of infants born to such women should continue to be promoted, supported and protected, because its benefits usually outweigh HIV risks.

Promote Breast-Feeding

The breast milk of mothers infected with HIV contains small numbers of the virus. Researchers have found that one-third of the babies born to HIV-infected women become infected themselves. Although this occurs mainly during pregnancy or child birth, and although a large majority of infants breast-fed by HIV-infected mothers do not become infected through milk, recent data confirm that transmission may occur through breast-feeding. The risk to the baby appears to



be 'substantial' if the mother herself becomes infected while breast-feeding, and 'lower' if she was already infected by the time she gave birth.

Nevertheless, breast milk offers far more benefits to the baby, especially in areas where infant deaths due to infectious diseases and malnutrition remain high. Particularly relevant to the South-East Asia Region is the recommendation of a WHO/UNICEF consultation on HIV transmission and breast-feeding which reads as follows:

"Where the primary causes of infant deaths are infectious diseases and malnutrition, infants who are not breast-fed run a particularly high risk of dying from these conditions. In these settings, breast-feeding should remain the standard advice to pregnant women, including those who are known to be HIV-infected, because their baby's risk of becoming infected through breast milk is likely to be lower than its risk of dying of other causes if deprived of breast-feeding. The higher a baby's risk of dying during infancy, the more protective breast-feeding is and the more important it is that the mother be advised to breast-feed. Women living in these settings whose particular circumstances would make alternative feeding an appropriate option might wish to know their HIV status to help guide their decision about breast-feeding. In such cases, voluntary and confidential HIV testing accompanied in all cases by pre- and post-test counselling could be made available where feasible and affordable."

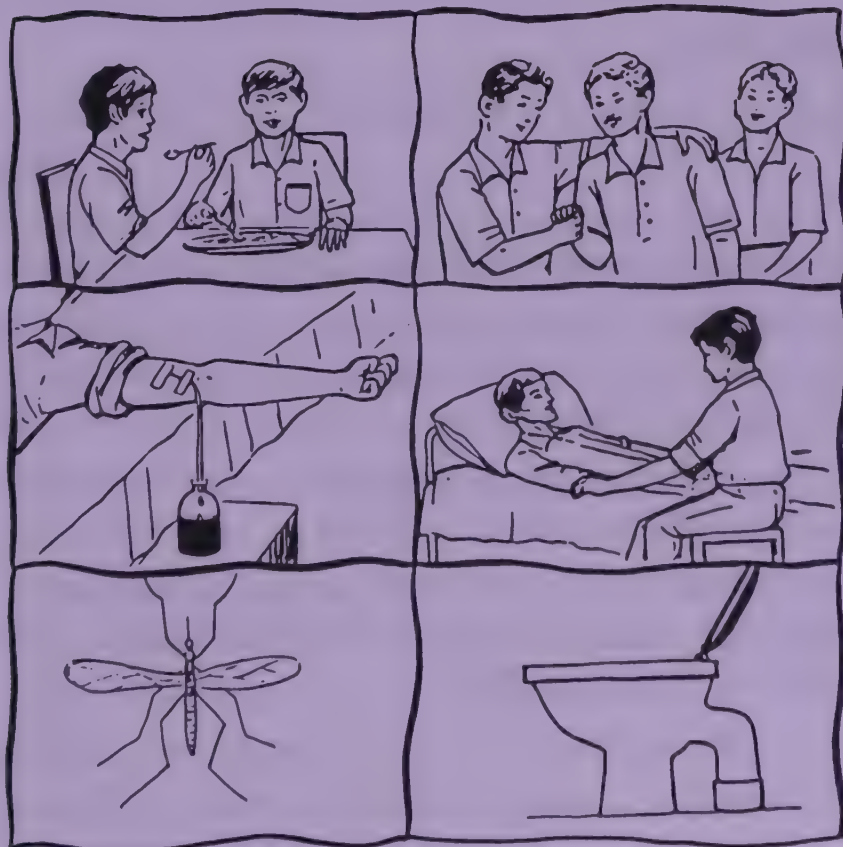
Roads That HIV Will Not Take

The range of present attitudes towards AIDS is similar to the attitudes once taken towards syphilis in the early 19th century. Myths and emotional hysteria can be generated due to misinformation about

AIDS. Many myths about HIV today centre around the manner in which it can be transmitted. Extensive research has shown that there are only three well-defined routes of HIV transmission, as discussed above. The studies show that:

HIV Does Not Spread By:

- Drinking water or eating food from the same utensils used by an infected person.
- Swimming in pools used by people with HIV or AIDS.
- Getting bitten by a mosquito that has already bitten an infected person.
- Getting bitten by an infected person.
- Socializing or casually living with people with HIV or AIDS.
- Caring and looking after people with HIV or AIDS.



- Use of the same toilets as AIDS patients or people infected with HIV.
- Shaking hands with people with HIV or AIDS.
- Hugging or kissing a person with HIV or AIDS.
- Casual contact such as sitting next to an infected person, or by coughing and sneezing, or from water, food, clothing, cups, glasses, plates, forks, spoons and other shared objects.
- Sharing the same telephone with an HIV-infected person.
- Receiving and reviewing literature from areas of the world where there is AIDS.
- Donating blood.
- Working with people who are HIV-infected.

**Bedbugs, flies, lice, fleas, mosquitoes and other insects and pests
DO NOT spread HIV.**

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4

Prevention of HIV

IN South-East Asia, where HIV infection may still be in its early stages, prevention of HIV infection, in time, assumes paramount importance. Realizing the socioeconomic impact of AIDS in the region, commitment for AIDS prevention and control is required at the highest political as well as operational levels.

Main Strategies

The strategy to combat AIDS has three main objectives: to prevent HIV infection; to reduce the personal and social impact of HIV infection; and to mobilize and unify national and international efforts against AIDS. *Prevention is indisputably the most important objective.* No curative drug or universally effective and affordable preventive vaccine is likely to be available in or accessible to developing countries in the foreseeable future. Since AIDS is essentially a sexually transmitted disease, sexual behaviour is the prime focus of action for interrupting transmission. It is therefore important to have an information and education programme aimed at all men and women, including adolescents, which is particularly aimed at those who are at greater

risk of HIV infection. It is also necessary to have facilities for the detection and treatment of other sexually transmitted diseases and to have an environment which promotes condom use and frank information dissemination without stigmatization and discrimination against people known or suspected to have HIV/AIDS. **In the South-East Asia Region, prevention of *sexual transmission* is an immediate and top-most priority.**

In order to prevent HIV transmission through infected **blood and blood products**, the approaches that have proven effective include recruiting voluntary non-paid donors, screening donated blood for HIV and educating health care workers to avoid unnecessary transfusions. Prevention of transmission at health care facilities rests on careful attention being given to infection control procedures including proper sterilization of equipment, proper adherence to procedures based on 'universal precautions', and provision of necessary supplies and equipment. Preventing blood-borne transmission among drug injectors should go hand-in-hand with efforts to prevent sexual transmission among them. These should include reducing the demand for and use of drugs by injection, and reducing the sharing of injection equipment.

The safety of blood and blood products, however, is an area where total control can be achieved by routine and mandatory screening of all donated blood for HIV. In many countries of the Region, all donated blood is now screened for HIV. In others, the proportion of blood screened is on the increase. Cost-effective approaches in HIV testing, including the testing of pooled sera, are also being promoted in populations where the seroprevalence of HIV is low. To avoid expensive tests, guidelines for alternative and cost-effective testing techniques have been implemented.

The best strategy for preventing transmission from *mother to child* is, of course, to prevent the sexual transmission of HIV to women of reproductive age. Secondary prevention depends on the

avoidance of child-bearing by women who know or suspect that they are infected. Counselling and contraceptives should be made available for all women.

WHO estimates that 30 million adults and children are now infected with HIV. Most of these will develop HIV-related illness and ultimately AIDS. Therefore, countries need to plan for the care of these patients at hospitals, in the community and at home. Common opportunistic infections such as tuberculosis must be treated. Infected individuals, in addition, need understanding and compassion to enable them to maximize their health and human potential. Because AIDS affects people in their most productive years, the impact on the families of people with AIDS is enormous, especially on children who may be orphaned. The impact of AIDS on society will include enormous health care costs, decimation of workforces and loss of skilled labour and educated professionals.

HIV/AIDS Prevention Package

- Promoting safer sex behaviour through education
- Condom promotion/provision
- STD diagnosis and treatment
- Safe blood transfusion
- Safe injecting behaviour

It is important, therefore, to recognize that AIDS is not just a health problem. It has major social and economic consequences. It also has political and ethical implications. In the South-East Asia Region, the challenge of denial and complacency needs to be overcome in order that effective AIDS prevention programmes

can be put in place with the highest level of political commitment. A broad-based, *multisectoral response* is urgently needed which includes NGOs since they can play a critical role in promoting safer sex practices, providing care and social support to people with HIV/AIDS and combatting complacency and stigmatization.

Key Interventions and Approaches

Information, education and communication (IEC)

In the absence of a cure or a vaccine, health education or IEC remains the primary tool for combatting the HIV pandemic. However, knowledge about HIV transmission and AIDS is presently confined to relatively few people. Moreover, it is important to realize that knowledge does not necessarily lead to action in terms of behavioural change.

In the South-East Asia Region, a number of challenges lie ahead in designing and implementing a good IEC programme. These include: overcoming public sensitivities about talking about sex/condoms; avoiding conflicting messages; lack of information on sexual behaviour and practices; difficulties in accessing target audiences; knowledge and attitudes of health care workers and others involved in interpersonal communication; low exposure to mass media; low literacy rates; stigmatization of population groups; and access to information.

Before embarking on an IEC programme, it is important to identify the target population as also the channel of communication. Priority must be given to:

- educating people who are at high risk such as sex workers and drug users through the use of interpersonal approaches (in collaboration with NGOs);

- educating school children through the school curriculum; and
- educating the general population using mass media.

In order for health education programmes to succeed, support services such as condoms and counselling and STD services must be made available. Social and behavioural research is necessary to assess the level of knowledge and to determine which channels of communication are appropriate and effective.

The WHO Regional Office for South-East Asia has recently developed guidelines for planning and implementing an IEC programme for STD/AIDS prevention which is available free of cost on request (see list of WHO/SEARO publications on AIDS). The guide explains, among other things, the need to improve interpersonal communication skills for targetted interventions, and the importance of coordinated IEC among all sectors, including NGOs.

Targeted Interventions

Targeted interventions are programmes or activities targeted to specific population groups to achieve specific objectives. In HIV/AIDS/STD work this refers to a package of activities such as IEC, provision of health services, condom distribution and counselling. Such activities are known to have a beneficial impact in reducing the burden of disease. The prevention and control of HIV infection in injecting drug users (IDUs) can be a more daunting task due to the complexity of the issues involved.

In all countries of the South-East Asia Region, the first objective is to prevent drug abuse. In countries with very low rates of use of illicit drugs and absence of trafficking networks, prevention of the



establishment of such a network through law enforcement is the first priority.

In other countries where drugs are widely used but rarely injected, for example in Sri Lanka and most parts of India, the first priority in containing the spread of HIV infection in drug users is to prevent a shift towards drug injecting. Public and mass media campaigns against injecting are probably counter productive in such a situation. They tend to raise curiosity rather than deter inhalers from switching to injecting drugs. By being marginalized and criminalized, drug users are unlikely to follow advice from the authorities or benefit from harm reduction programmes. There is already an example to prove this point. A rapid switch to drug injecting in Nepal followed a strong media campaign against injecting drug use. Only low key, peer-to-peer programmes are likely to be effective in such situations.

Injecting drug use is already widespread in Myanmar, Thailand and some states in India, although initiation into drug use still occurs almost invariably by smoking/inhaling. In such situations, in addition to an abstinence-oriented treatment approach, a series of subtle harm reducing strategies is being promoted. These include oral opiate maintenance; peer-to-peer programmes for converting drug injectors into drug inhalers; and education for decontamination of needles and syringes with bleach (5 per cent sodium hypochlorite). These measures should be combined with outreach programmes for those drug users who are still untouched by the existing systems of help. In countries where multi-load droppers are used for injecting, thereby considerably increasing the amount of blood exchanged, as in Myanmar and some north-eastern states of India, substitution with single-load droppers and/or syringes should be an immediate priority.

Realistic Alternatives for Drug Users

- Stop taking drugs.
- If you cannot stop, do not inject drugs.
- If you must inject, use only sterile injection equipment (syringe and needle). Do not share needles and syringes with others.
- Even if this cannot be done, sterilize injecting equipment with household bleach each time before use.

Targeted Interventions among Commercial Sex Workers

In 1992, the National AIDS Control Organization (NACO) in India, in collaboration with WHO, initiated an STD/HIV intervention

programme for CSWs of the Sonagachi red light district in Calcutta. A baseline survey revealed that out of 360 CSWs tested, 80.5% were infected with one or more STDs. For the purpose of the survey, a clinic was established in the district which then served as a general health outreach facility focusing on STDs and sexual health. The intervention also developed an innovative approach to raising HIV/AIDS awareness among CSWs and promoting the use of condoms through recruiting selected CSWs themselves to work as peer educators. Now numbering 65, peer educators also provide the necessary support needed for behaviour change and through their work have earned special status in the community gaining self-respect and dignity. A repeat survey conducted in Sonagachi in 1993 showed that both STD and AIDS awareness had increased - from 69% to 90.5% and from 31% to 85.8% respectively, while 47.2% were now using condoms against 1.1% a year before. The incidence of STDs had also dropped from 80.5% in 1992 to 59% in 1993.

Control of sexually transmitted diseases (STD)

Epidemiological data worldwide as well as in South-East Asia show that the major mode of HIV transmission is through sexual intercourse and that HIV is primarily a sexually transmitted disease. The relationship between STD and AIDS is two-fold: (1) STDs are a marker for high-risk behaviour, the same high-risk behaviour predisposing for HIV infection as predisposes for STD: unprotected sexual intercourse with multiple partners; and (2) STDs appear to serve as important risk factors which facilitate the transmission and acquisition of HIV infection. Thus, control of STDs contributes significantly to a reduction in HIV transmission. This has been demonstrated recently in Tanzania where STD case management integrated into primary health care reduced the incidence of HIV by 40%.

General Principles of STD Control at the Primary Health Care Level

Main aims:

- To interrupt the transmission of sexually transmitted infections.
- To prevent the development of complications associated with STDs and their consequences.

These can be achieved by:

- Educating people to change their behaviour.
- Encouraging the use of condoms.
- Promoting appropriate health-seeking behaviour.
- Providing acceptable, accessible and effective clinical services.
- Encouraging sexual partners, and particularly asymptomatic or poorly symptomatic women, to attend clinical services.

Source: Derived from Management of Patients with Sexually Transmitted Diseases: Report of a WHO Study Group. Geneva, World Health Organization, 1991 (WHO Technical Report Series No. 810).

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Three main strategies can be identified for STD control. These are:

- IEC – to effect behavioural change towards safer sex. IEC activities can be targeted at the general public or at special target groups. STD patients are special target group for IEC and for individual counselling. Their current infections and the awareness of their vulnerability to HIV might make STD patients more willing to contemplate behavioural changes.
- Early detection using syndromic diagnosis and provision of most effective drugs at patients' first contacts with the health services.
- Uninterrupted supply of drugs.

Condom promotion and provision

Several studies have demonstrated that the use of condoms during sexual intercourse reduces the risk of transmitting or acquiring infection with HIV as well as other STDs and that proper and consistent condom use can play an important role in AIDS prevention. Condoms are however not perfect and can vary in quality depending on manufacturing technology and practices and prevailing standards.

Major challenges remain in the promotion of use of condoms in South-East Asia which include social, cultural and religious sensitivities, lack of access to condoms, and inability to talk frankly about condoms or sex.

Social marketing of condoms is emerging as a successful approach for promoting condoms and enhancing their availability for use among people with multiple sex partners and among youth.

Interventions aimed at specific targets like the '100 per cent condom-use programme' in Thailand are success stories which blaze a trail for future programmes.

Thailand's 100% Condom Programme

The 100% condom programme in Thailand is an attempt made by the Thai authorities to ensure, by administrative means, that condoms are used in commercial sex establishments at *all* times. The programme demands that if a client refuses to use a condom, the commercial sex worker (CSW) withholds her services and refunds the money paid. The programme uses sanctions and the threat of sanctions against establishments where condoms are not used with every sex encounter.

A mass advertising campaign which promoted condom use in commercial sex complemented the programme. The results have been impressive. Condom use rose from 14% in 1989 to over 90% in 1994 and STD incidence in the country has dropped dramatically. Moreover, HIV infection rates among young adults such as military recruits have begun to decline.

The programme which began in 1989 in just one province in Thailand has now been adopted as a nationwide programme. It's success has been attributed both to the mass advertising campaign which accompanied it as well as to the fact that the programme focused on the use of condoms in commercial sex to the exclusion of other goals such as elimination of prostitution.

Additional Reading

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5

Managing HIV/AIDS: Care and Support

THE management and care of HIV/AIDS persons involves a continuum of care requiring the services of people working at various levels – in hospitals, clinics and health centres, and with NGOs and care providers in the community and home. At each of these levels some or all of the following can be provided – medical and nursing care, counselling and social support. Even at home, home-based care can incorporate many of these components. Significant improvement in the quality of life has resulted when such care is made accessible to individuals and families.

There are some good examples of HIV/AIDS care programmes in the Region such as the Manipur Continuum of Care Project in India and the Community-Based Prevention and Control Project in northern Thailand.

Medical and Nursing Care

HIV-infected persons have repeated episodes of illness and impairment requiring medical and nursing care, including occasional

hospitalization. At the minimum, such clinical care should include pain relief and treatment for common opportunistic infections; this requires adequately trained health care providers and a reliable supply of essential drugs and medicines. In developing countries, treatment of opportunistic infections is most important since the cost of antiviral drugs is prohibitive.

Clinical care of a person with HIV/AIDS can considerably prolong his or her life and improve its quality. However, there is still an element of conflict within the medical profession, particularly in the developing world. Since AIDS has no cure, the meagre resources, it is felt, may be better utilized for treating other diseases for which a cure is known. Coupled with this are myths about HIV and AIDS which have made the medical and nursing management of people with HIV or AIDS a very difficult task indeed. There is also a lurking fear among health care workers of the risks of acquiring the infection from their patients.

Infection Control

It is true that those working in health care settings - doctors, nurses and paramedical staff – run a risk of getting infected accidentally by HIV from a patient if they are not careful. They can also transmit the virus to an uninfected patient, if they themselves are infected with HIV and do not take the necessary steps to prevent it happening. Such risks can be avoided by following **universal precautions**, a set of measures taken to ensure that accidental exposure of patients and health care providers to potentially infectious blood is reduced to the absolute minimum. Universal precautions are based on the assumption that all blood is potentially infectious regardless of whether it is from a patient or health care worker and regardless of their known HIV antibody status, and should be applied in the case of all patients.

Universal Precautions

Universal precautions consist of four standard practices:

- Safe handling and disposal of sharps
- Safe decontamination of instruments and other contaminated equipment
- Handwashing
- Use of protective barriers to prevent direct contact with body fluids

The most common way in which health care providers are exposed to HIV is through accidental exposure to sharp objects. This can be avoided, for example, by not recapping, bending or breaking needles, and disposing of them in puncture-proof containers. In fact, health care settings should follow the same principles of cleanliness, sterility, hygiene and precautions which they have been following for other viruses like the Hepatitis B Virus (HBV). HIV is an extremely delicate virus which can be easily destroyed by simple methods such as boiling for 20 minutes or using chemicals such as household bleach. It is important to remember that infection control measures are intended to isolate the virus and body fluids, not the patient.

Home Care

Since AIDS is a chronic disease lasting months or years, much of the care of those with AIDS must therefore occur at home. Families and other care providers must be helped to provide safe and compassionate home care to people with AIDS. This can be done through information and training programmes. Care providers

including the infected person must be made aware of how HIV is transmitted, what medical problems can arise, what they can do to prevent or treat them and when and from whom they should seek help. Clean hygienic practices at home, good nutrition, adequate rest and prompt treatment in case of illness will go a long way in prolonging the life of an HIV/AIDS person. Recognizing and taking care of the emotional needs of the HIV-infected person is equally important. Home care providers can play an effective role in promoting and sustaining a cheerful atmosphere at home and helping the person infected with HIV to live as normal and satisfying a life as possible.

Counselling and Support

Managing HIV/AIDS does not only include clinical care. Diagnosis of HIV infection or AIDS in a person or a suspicion or recognition of the possibility of infection brings with it, in addition to medical consequences, profound emotional, social and behavioural consequences. The subsequent individual and social adjustments required often have implications for family life, sexual and social relations, work, education, spiritual needs, legal status and civil rights. HIV-infected persons need understanding, compassion and social support. Adjustment to HIV infection involves constant stress management and adaptation. Counselling is therefore an equally vital part of care. It is a dynamic evolutionary and lifelong process that makes new and changing demands on infected individuals, their families and the communities in which they live.

HIV/AIDS counselling is a relationship between a client and care provider, aimed at enabling the client to cope with stress and to take personal decisions relating to HIV/AIDS. The counselling process includes the evaluation of personal risk of HIV transmission and the facilitation of preventive behaviour. In this way, counselling

is different from education, because education involves spreading specific messages to larger groups of people.

HIV/AIDS counselling goes beyond HIV/AIDS education by assisting people to deal with their emotional stress, by personalizing education messages and by enabling a confidential personal risk assessment to assist the client in making the lifestyle changes needed to prevent transmission of HIV. Counselling must be provided in confidential settings. This has helped individuals cope and find support in dealing with the news of being HIV positive. Mutual support is also often found through the formation of support groups or community centres. This is most beneficial when the community is accepting and does not stigmatize those using and providing the service. During counselling, opportunities to involve and educate families can take place with the client's consent. Where appropriate, spiritual support, condoms and other materials can also form part of a supporting environment.

Counselling seeks to help infected people make decisions about their life, boost their self confidence, and improve family and community relationships and quality of life. HIV/AIDS counselling also provides support to the families and loved ones of infected people, so that they in turn can provide encouragement and care for those with HIV infection.

Counselling can help people to live and cope with HIV and AIDS by taking into account the client's immediate social and medical environment and his or her social relationships and attitudes and beliefs about HIV/AIDS. Counselling has to provide education and information in a way that is relevant to the day-to-day life of the person concerned. It has to take account of such things as the patient's sexual needs and history, occupation, education, aspirations, and hopes, together with what it will take to inspire a new approach to safer sex and responsible social relationships.

Preventive counselling has also helped individuals to change behaviour. Counselling should therefore not be restricted to HIV infected persons and their families or loved ones, but it should be available to all those who are at risk of getting infected, including patients with sexually transmitted diseases.

Ethics of AIDS

It is unethical to stigmatize or discriminate against people who are HIV-infected or who have AIDS. Human rights demand that people with HIV/AIDS be treated exactly like other people in terms of access to health care, work, education, travel, social welfare services, etc. Non-discrimination is not only a human rights imperative but is also a technically sound strategy for ensuring that infected persons are not driven underground where they become inaccessible to education or health care programmes and unavailable as credible bearers of AIDS prevention messages for their peers. Any attempt to isolate, detect and confine infected persons is therefore not only unethical but is also, from a public health point of view, quite irrational. For every known HIV positive individual there may be hundreds of other asymptomatic individuals capable of spreading the infection to the population. By isolating the 'drop in the ocean' it would be foolish to believe that all infected persons are now out of reach and that precautions against sexual transmission of HIV are no longer necessary. The ethics of AIDS also involves the ethics of HIV testing. Given the possibility of discrimination against and ostracism of an individual diagnosed as having HIV infection, it is also extremely important that the results of such tests are kept confidential.

In 1992, the World Health Assembly in a resolution endorsed that 'there is no public health rationale for any measures that limit the rights of the individual, notably measures establishing mandatory

screening'. WHO recommends HIV testing only for selected purposes. These include (a) screening of blood including blood products and organs and tissues for transplantation; (b) epidemiological surveillance, particularly HIV sentinel surveillance using unlinked anonymous HIV testing methodology; (c) diagnosis of symptomatic infection among those clinically suspected of having AIDS (with informed consent); and (d) early diagnosis of HIV infection among asymptomatic persons who would like to know their HIV status (with informed consent).

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6

Preventing HIV and Providing Care: Whose Responsibility?

THE prevention and control of AIDS, however, should not be seen as the sole responsibility of the health services. What is required is commitment at all levels – individual, the family, health personnel, media, etc.



Individual

Individuals must adopt a lifestyle and behaviour which is compatible to health and prevents the transmission of HIV. Individuals with HIV/AIDS must take personal responsibility to ensure that they will stop the further spread of the virus.

Family

Families must adopt values which promote health. The family must provide understanding, compassion and care to help any family member with HIV/AIDS in coping with the unusual situation and in staying healthy.



Society

Societies must avoid discriminating against people with HIV/AIDS and promote a supportive environment to facilitate behaviour change. Societies must also strive to minimize the losses incurred by AIDS cases through providing financial and other support.

Health Personnel

All health personnel have the responsibility of providing care and counselling to people with HIV/AIDS. They must take appropriate precautions to prevent the spread of the infection in health care settings;



act as a role model for their community by providing compassionate and respectful care; and educate individuals and groups about the facts related to HIV and its transmission.

Health Educators



Health educators include all those involved in educating people about health using various methods to initiate a learning process in communities. Health educators have an important role to play in facilitating behavioural change that will prevent the spread of HIV/AIDS. As part of a worldwide education effort, WHO focuses on an important theme related to AIDS each year on 1 December, which is observed as World AIDS Day.

Policy Makers

Policy-makers have a very special responsibility. Through sound policies and strong commitment to the national AIDS prevention and control programmes, policy-makers must ensure that the implementation of the programme is backed by clearly developed national policies that will facilitate and accelerate programme implementation rather than slow it down.



There is need for clearly stated policies on a number of issues covering both the public health as well as the socioeconomic and ethical aspects of HIV/AIDS prevention and care. These include, among others issues related to HIV testing, confidentiality, discrimination, care, condom promotion and AIDS education in schools.

Nongovernmental Organizations (NGOs) and the Private Sector

Various sectors are now being involved in AIDS prevention and control, including NGOs and the private sector, in most countries of the Region. NGOs have an important role to play in the prevention and care of HIV/AIDS. To

begin with, they often work in areas and regions not covered by government programmes and work with marginalized groups who are ordinarily difficult to access. NGOs have also shown greater flexibility in undertaking programmes and testing innovative approaches. Besides, their closeness to the



communities they work with and the credibility gained thereby, make them more effective implementors of intervention programmes targeted at people practising high-risk behaviours as well as other vulnerable groups such as women. Above all, NGOs play an important collaborative role in the planning, implementation and evaluation of National AIDS Programmes.

WHAT NGOs CAN DO

- Raise awareness in individuals, groups and communities on HIV/AIDS prevention and care.
- Implement targeted intervention programmes for behaviour change in people at risk of getting infected with HIV.
- Provide and facilitate access to health services including STD services especially for marginalized population groups.
- Promote the distribution and use of condoms.
- Promote voluntary blood donation.
- Carry out advocacy programmes to protect human rights and counter discrimination against people with HIV/AIDS.
- Provide care and support including counselling services to those at risk and those infected and affected by HIV/AIDS.
- Collaborate and network with concerned groups and organizations, both government and non-government, in the fight against AIDS.
- Mobilize resources for AIDS prevention and care.
- Participate in socio-behavioural qualitative research studies related to HIV/AIDS.

The private sector also has a significant role in HIV/AIDS prevention and care. Clear policies prepare businesses to deal with HIV/AIDS responsibly and effectively. HIV/AIDS education and prevention activities assist workers and their families to prevent the spread of HIV/AIDS. Businesses will derive great benefit from such programmes, such as reduced costs, stable productivity and a healthier workforce.

In Thailand, major businesses, both national and multinational, came together to form a 'business coalition against AIDS' and to mount an appropriate 'business' response to AIDS. In India, the Consortium of Indian Industries developed work plans for AIDS prevention activities to be carried out in industry. NGOs' activities greatly increased during the biennium in all countries, particularly in peripheral areas. Collaboration between NGOs and national programmes, and among NGOs themselves increased. In Myanmar, community involvement in AIDS prevention, including contributions from NGOs and the private sector such as small traders and merchants at the township level, are particularly noteworthy.

Mass Media

The mass media represents the most readily available and potentially most economical means of imparting information about HIV/AIDS. Along with other forms of communication, the mass media can effectively raise public awareness and concern about HIV/AIDS. However, mass media have to adopt a responsible attitude in reporting about HIV/AIDS, avoiding inaccuracies and distortions which may generate misconceptions about HIV/AIDS.



Mass media must be careful not to sensationalize news about AIDS, which can cause undue panic. According to the London-based

UK NGO AIDS Consortium for the Third World, media reports can be misleading due to:

- Inaccuracies, or careless use of language.
- Indiscriminate reporting of scientific information, or unbalanced selection of scientific stories.
- Misinterpretation or sensationalizing of information.
- Personal attitudes of reporters and editors which have influenced their reporting.
- Misleading headlines, subheads and editorial introductions.
- Repeating information, which though reported accurately at the time, has later been proved wrong.
- Failure to keep pace with rapidly changing information.
- Unfortunate use of quotes which seem to give credence to inaccurate and sometimes damaging misinformation.

Using the Right Language while Communicating about HIV/AIDS*

It is very important for the mass media to adopt standard terminology while talking or writing about HIV/AIDS. This should be aimed at overcoming the problems that are related to using terms and references which are discriminatory and seem to pass judgement on people with HIV/AIDS. Standard terminology will also give a sense of perspective to media personnel while dealing with issues relating to HIV/AIDS and help the media refrain from sensationalizing or over-reacting. This would also help in objective, clear and accurate reporting, and avoid misconceptions and mass hysteria about HIV/AIDS.

*Source: National Union of Journalists, London, and UK NGO AIDS Consortium for the Third World

Terms To Avoid	Why?	Use Instead
Aids	First, because the word already means many things. Second, because it is an acronym for acquired immuno-deficiency syndrome and using capitals helps to remind readers.	AIDS
Carrying AIDS, AIDS carrier, AIDS positive	This confuses the two distinct phases of being infected with HIV and having AIDS. People can "have" AIDS but can't "carry" it.	HIV antibody positive/people living with HIV or AIDS
AIDS test	The most commonly used test detects antibodies to HIV. There is also an "antigen" test, which detects the presence of the virus itself. This is not widely used. There cannot be a test for AIDS, as this depends on a diagnosis according to clinical symptoms.	HIV antibody test
AIDS virus	Often used as a shortened term, by WHO among others, this can easily cause confusion between HIV and AIDS unless used with caution.	HIV (human immuno-deficiency virus)
Catching AIDS (i.e. become infected with HIV)	It is not possible to catch AIDS. It is possible to catch HIV, but even this is misleading as it suggests transmission is similar to colds or flu.	Contract HIV/become HIV positive

Terms To Avoid	Why?	Use Instead
Catch AIDS (i.e. develop AIDS)	It is not possible to catch AIDS. It is possible to catch HIV, but even this is misleading as it suggests transmission is similar to colds or flu.	Develop AIDS/have a diagnosis of AIDS
AIDS sufferer	Having AIDS does not mean being ill all the time. Someone with AIDS can continue to work and live a normal life for some time after diagnosis. Suffering is, therefore, not appropriate.	Person with AIDS
AIDS victim	Suggests helplessness, which is no longer appropriate.	Person with AIDS/person who has AIDS
Innocent victim	Suggests someone else with AIDS is guilty.	
HIV case	The word "case" is usually used in relation to a clinical condition.	Person with HIV
High risk groups	It is now clear that there is risk behaviour, not high risk groups. The fact of being classified as a member of any particular group does not put anyone at greater risk, but what he or she does, regardless of groups, may do.	People who practice high risk behaviour
Full-blown AIDS	When the correct distinction between HIV and AIDS is always made, there is no need to use the term "full-blown AIDS".	AIDS

Use With Care	
Promiscuous	Implies a moral overtone which is inappropriate.
Prostitute	Not everyone who has many partners is a "prostitute". Not everyone who takes money or goods in exchange for sex has many partners.
AIDS patient	Only appropriate when someone is ill. Care is needed to distinguish this from HIV infection, when "patient" is not appropriate.
Catastrophe, Disaster	There are still very few parts of the world where this is an accurate description as far as the incidence of HIV/AIDS is concerned.
Plague	Plague suggests a specific contagious disease, which AIDS is not. Epidemic is a better description.

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Vaccine and Drug Development

Vaccine Development

INITIAL attempts to develop potential HIV vaccines were hindered by a number of obstacles, primarily the failure of experimental vaccines to protect animals from HIV infection. There is now a general consensus that a vaccine suitable for preventing HIV infection in humans is unlikely to be developed any time soon. To facilitate and accelerate these efforts, a WHO strategy in the past has been developed to coordinate activities in the development, evaluation and availability of vaccine. This strategy covered all three potential types of HIV vaccine, i.e., preventive, therapeutic and perinatal vaccines.

HIV has at least six different sub-types – A, B, C, D, E and F. In Thailand, two sub-types (B and E, the latter being more common) have been found, while in India at least three sub-types have been identified (C is the commonest). This has important implications for vaccine development. Ideally if a vaccine has to be effective in all countries it will have to be a cocktail containing all sub-types of the virus.

As of October 1995, sixteen candidate vaccines had undergone or were undergoing phase 1 or 2 trials. Any vaccines that prove safe

and immunogenic in these trials will be tested in large-scale efficacy trials. Thailand is one of four countries that have been selected by WHO for vaccine field trials.

AIDS vaccine development is complicated by the considerable genetic variability of HIV in different geographical areas and even within an infected person over time. This genetic variation needs to be completely understood if HIV vaccines are to be effective and appropriate for use in populations in both developed and developing countries.

Drug Development

The magnitude of the AIDS pandemic has promoted an unprecedented effort among pharmaceutical manufacturers and research laboratories to identify new or existing drugs which are effective against HIV and HIV-related infections. As a result of this effort, three anti-HIV drugs have been licensed: zidovudine (AZT), dideoxyinosine (ddI) and dideoxycytidine (ddC). Unfortunately, all these drugs are expensive and can cause severe adverse reactions, which prevents their widespread use in developing countries where health care budgets and laboratory capacity for monitoring adverse reactions are limited. Moreover, when used alone, the virus rapidly develops resistance to these drugs. Recent studies show that combination therapy using different combinations of drugs including AZT, ddI, ddC and newer drugs (for example protease inhibitors like saquinavir, zidovudine and zalcitabine) is more effective and may even reduce virus load to such extent that it becomes virtually undetectable. However, combination therapy is also more expensive, costing 12 000 to 18 000 US dollars per year, rendering them virtually inaccessible for those in the developing world. On the other hand, drugs for the treatment of opportunistic infections, such as tuberculosis and fungal infections, on the other

hand, have been shown to be effective and suitable for use in HIV-infected people. The use of such drugs should therefore be encouraged in developing countries to improve the quality of life and prolong the survival of people with AIDS.

Tuberculosis is an important HIV-related disease because of its high prevalence in developing countries and because of the association it has with HIV infection. TB is also a serious public health problem because of its potential for secondary spread to uninfected – i.e. HIV-negative – people. The disease is especially important in sub-Saharan Africa, where it has been found that up to 50% of newly diagnosed pulmonary tuberculosis patients are also infected with HIV. In Chiang Mai (Thailand) and Bombay (India), HIV infection rates among TB patients have now reached 40% and 25% respectively. TB is now the most important opportunistic infection associated with HIV since 50-70% of AIDS patients in many Asian countries suffer from tuberculosis. Currently the emphasis is on ensuring a high cure rate by treating properly all cases of diagnosed tuberculosis with short course chemotherapy under supervision.

Controlled studies on drugs for other HIV-related infections and symptoms, such as oral and oesophageal candidiasis and chronic diarrhoea, are now being conducted. These studies will test the efficacy of available regimens for the prevention, treatment and prevention of relapse with these conditions. Vaginally inserted virucidal tablets or suppositories may reinforce the effectiveness of condoms in preventing the sexual transmission of HIV and represent a particularly important female-controlled prevention technology which may ultimately prove to be effective on its own. One of the spermicides/virucides is menfegol, which is widely available in developing countries as a contraceptive agent. WHO is supporting a phase 1 and 2 safety study of a new application of this drug, i.e. in a regimen of up to 8 doses per 24-hour period, in Senegal and Thailand.

Additional Reading

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8

AIDS: Questions and Answers

AIDS and Its Prevention

Q: What are HIV and AIDS?

A: AIDS (acquired immunodeficiency syndrome) is the late stage of infection with human immunodeficiency virus (HIV). AIDS can take more than 8-10 years to develop after infection with HIV. HIV-infected people can live symptom-free lives for years; however most people in developing countries die within three years of being diagnosed with AIDS.

Q: How do people get infected with HIV?

A: HIV is transmitted mostly through semen and vaginal fluids during unprotected sex without the use of condoms. Globally, most cases of sexual transmission involve men and women, although in some developed countries homosexual activity remains the primary mode. Besides sexual intercourse, HIV can also be transmitted during drug injection by the sharing of needles contaminated with infected blood; by the transfusion of infected

blood or blood products; and from an infected woman to her baby – before birth, during birth or just after delivery.

HIV is not spread through ordinary social contact; for example by shaking hands, travelling in the same bus, eating from the same utensils, by hugging or kissing. Mosquitoes and insects do not spread the virus nor is it water-borne or air-borne.

Q: How many people are affected with HIV?

A: According to WHO estimates, by end-1996, nearly 30 million people - including over 2.5 million children - had been infected with HIV since the start of the pandemic. Every day, more than 7000 adults and 500 babies are infected. More than 8 million people have developed AIDS.

Q: Does AIDS also affect our region?

A: Of the 26.8 million adults with HIV infection – the global estimate in end-1996 – 14 million were in Sub-Saharan Africa and more than 3.5 million in Asia. Our region, that is South-East Asia, is likely to suffer the brunt of the pandemic - being home to over half the world's population. Moreover, HIV/AIDS is now present in every continent and in every region of the world.

Q: Why is the AIDS epidemic considered so serious?

A: AIDS affects people primarily when they are most productive and leads to premature death thereby severely affecting the socioeconomic structure of whole families, communities and countries. Besides, AIDS is not curable and since HIV is transmitted predominantly through sexual contact, and with sexual practices being essentially a private domain, these issues are difficult to address.

Q: How can I avoid being infected through sex?

A: You can avoid HIV infection by abstaining from sex, by having a mutually faithful monogamous sexual relationship with an uninfected partner or by practicing safer sex. Safer sex involves the correct use of a condom during each sexual encounter and also includes non-penetrative sex.

Q: Can we assume responsibility in preventing HIV infection?

A: Both men and women share the responsibility for avoiding behaviour that might lead to HIV infection. Equally, they also share the right to refuse sex and assume responsibility for ensuring safe sex. In many societies, however, men have much more control than women over when, with whom and how they have sex. In such cases, men need to assume greater responsibility for their actions.

Q: Does the presence of other sexually transmitted diseases (STDs) facilitate HIV transmission?

A: Yes. Every STD causes some damage to the genital skin and mucous layer, which facilitates the entry of HIV into the body. The most dangerous are:

- syphilis
- chancroid
- genital herpes
- gonorrhoea

Q: Why is early treatment of STD important?

A: High rates of STD caused by unprotected sexual activity enhance the transmission risk in the general population. Early treatment of STD reduces the risk of spread to other sexual partners and also reduces the risk of contracting HIV from infected partners. Besides, early treatment of STD also prevents infertility and ectopic pregnancies.

Q: How can children and young people be protected from HIV?

A: Children and adolescents have the right to know how to avoid HIV infection before they become sexually active. As some young people will have sex at an early age, they should know about condoms and where they are available. Parents and schools share the responsibility of ensuring that children understand how to avoid HIV infection, and learn the importance of tolerant, compassionate and non-discriminatory attitudes towards people living with HIV/AIDS.

Q: How does a mother transmit HIV to her unborn child?

A: An HIV-infected mother can infect the child in her womb through her blood. The baby is more at risk if the mother has been recently infected or is in a later stage of AIDS. Transmission can also occur at the time of birth when the baby is exposed to the mother's blood and to some extent transmission can occur through breast milk. Transmission from an infected mother to her baby occurs in about 30% of cases.

Q: Can HIV be transmitted through breast-feeding?

A: Yes. The virus has been found in breast milk in low concentrations and studies have shown that children of HIV-infected mothers can get HIV infection through breast milk. Breast milk, however, has many substances in it that protect an infant's health and the benefits of breast-feeding for both mother and child are well recognized. The slight risk of an infant becoming infected with HIV through breast-feeding is therefore thought to be outweighed by the benefits of breast-feeding.

Q: Can blood transfusions transmit HIV infection?

A: Yes. If the blood contains HIV. In many places blood is now screened for HIV before it is transfused. If you need a transfusion,

try to ensure that screened blood is used. You can reduce the chances of needing a blood transfusion by taking ordinary precautions against serious injury - for example, by driving carefully, insisting on wearing a seat belt, and avoiding alcohol.

Q: Can injections transmit HIV infection?

A: Yes. If the injecting equipment is contaminated with blood containing HIV. Avoid injections unless absolutely necessary. If you must have an injection, make sure the needle and syringe come straight from a sterile package or have been sterilized properly; a needle and syringe that has been cleaned and then boiled for 20 minutes is ready for reuse. Finally, if you inject drugs, of whatever kind, never use anyone else's injecting equipment.

Q: What about having a tattoo or your ears pierced?

A: Tattooing, ear piercing, acupuncture and some kinds of dental work all involve instruments that must be sterile to avoid infection. In general, you should refrain from any procedure where the skin is pierced, unless absolutely necessary.

Q: How serious is the interaction between HIV and TB in South-East Asia?

A: Tuberculosis kills nearly 3 million people globally, of whom nearly 50% are Asians. The rapid spread of HIV in the region has further complicated the already serious situation. Not only is TB the commonest life-threatening opportunistic infection among patients living with AIDS, but the incidence of TB has now begun to increase, particularly in areas where HIV seroprevalence is high. Multi-drug resistant TB is also quite common in many areas.

Q: What efforts are being made to integrate HIV/AIDS/STD prevention and control activities into primary health care?

A: Integration into primary health care is a priority because it is necessary for ensuring sustainability. Two examples of an integrated approach are the implementation of HIV/AIDS care and STD prevention and control. For example, a continuum of HIV/AIDS care is being promoted as part of primary health care, with linkages to be established between institutional, community and home levels. In the area of STD prevention and control, a syndromic approach to STD diagnosis is most suitable in the developing world as it does not require laboratory tests, and treatment can be given at the first contact with health services. WHO strongly advocates that all primary health care workers be trained in the syndromic approach to STD management.

Q: Is there a vaccine for HIV/AIDS? What is WHO's role in this regard?

A: While there is currently no vaccine for HIV/AIDS, research is under way. Sixteen candidate vaccines are presently undergoing either phase I or phase II clinical trials in various countries, including Thailand in South-East Asia. These will be followed by field trials in the community to determine efficacy, which is a time consuming process and will take another 3-5 years or more. Hence, a vaccine for general use is unlikely to be available in the near future.

WHO's role is to assist in the development, evaluation and availability of vaccines. WHO has helped four countries – Brazil, Rwanda, Thailand and Uganda – to prepare a comprehensive plan for HIV vaccine research including strengthening of national epidemiological, laboratory and socio-behavioural research capabilities.

Q: Is there a treatment for HIV/AIDS?

A: All the currently licensed anti-retroviral drugs, namely AZT, ddI and ddC, have effects which last only for a limited duration. In

addition, these drugs are very expensive and have severe adverse reactions while the virus tends to develop resistance rather quickly with single-drug therapy. The emphasis is now on giving a combination of drugs including newer drugs called protease inhibitors; but this makes treatment even more expensive.

WHO's present policy does not recommend antiviral drugs but instead advocates strengthening of clinical management for HIV-associated opportunistic infections such as tuberculosis and diarrhoea. Better care programmes have been shown to prolong survival and improve the quality of life of people living with HIV/AIDS.

Q: How should governments share responsibility?

A: Governments are responsible for ensuring that enough resources are allocated to AIDS prevention and care programmes, that all individuals and groups in society have access to these programmes, and that laws, policies and practices do not discriminate against people living with HIV/AIDS. Governments of developed countries have a moral responsibility to share the AIDS burden of developing countries.

Q: Do people living with HIV/AIDS have special rights or responsibilities?

A: Since everyone is entitled to fundamental human rights without discrimination, people living with HIV/AIDS have the same rights as seronegative people to education, employment, health, travel, marriage, procreation, privacy, social security, scientific benefits, asylum, etc. Seronegative and seropositive people share responsibility for avoiding HIV infection/re-infection. But many people, including women, children and teenagers, cannot negotiate safe sex because of their low status in society or lack of personal power. Therefore men, whether knowingly infected or unaware of their HIV status, have a special responsibility of not putting others at risk.

AIDS Background

Q: Where did AIDS come from?

A: AIDS is caused by a virus called HIV, but where this virus came from is not known. However, as new facts are discovered about viruses like HIV, the question of where HIV first came from is becoming more complicated to answer. Moreover, such questions are no longer relevant and do not help in our efforts to combat this epidemic. What is more important is the fact that HIV is present in all countries and we need to determine how best to prevent the further spread of this deadly virus.

Q: Where was AIDS first found?

A: AIDS was first recognized in the United States in 1981. However, it is clear that AIDS cases had occurred in several parts of the world before 1981. Evidence now suggests that the AIDS epidemic began at roughly the same time in several parts of the world, including the U.S.A. and Africa.

Q: But how can there suddenly be a disease that never existed before?

A: If we look at AIDS as a worldwide pandemic, it appears as if it is something new and rather sudden. But if we look at AIDS as a disease and at the virus that causes it, we get a different picture. We find that both the disease and the virus are not new. They were there well before the epidemic occurred. We know that viruses sometimes change. A virus that was once harmless to humans can change and become harmful. This is probably what happened with HIV long before the AIDS epidemic.

What is new is the rapid spread of the virus. It may be compared with a weed that someone brings home from a distant place. In its original environment the weed survives but does not spread much. However, once it takes root in the new environment,

conditions may allow it to grow much better than it did before. It spreads, chokes out other plants, and becomes a nuisance. The spread of HIV is somewhat similar.

Researchers believe that the virus was present in isolated population groups years before the epidemic began. Then the situation changed; people moved more often and travelled more; they settled in big cities; and lifestyles changed, including patterns of sexual behaviour. It became easier for HIV to spread through sexual intercourse and contaminated blood. As the virus spread, the disease which was already in existence became a new epidemic.

AIDS and Women

Q: Are women at equal risk of getting infected with HIV?

A: Women are in fact more at risk of getting infected because of their increased vulnerability. In addition, their low status within the family and society further heighten their vulnerability to infection. It is therefore most important that every woman has access to information about HIV/AIDS to protect herself.

AIDS and Children

Q: Does AIDS affect children?

A: Yes. Children can be both infected and affected by AIDS. Over 2.5 million children worldwide are now infected with HIV. If HIV continues to spread in countries, there will be a great increase in deaths among infants and children. It is also estimated that by the year 2000, 10 million children will have been orphaned as their parents die of AIDS.

AIDS and Care

Q: Who should provide care to HIV/AIDS affected persons?

A: Everyone in contact with an HIV/AIDS person is a potential care provider. In particular, this includes health care workers at various levels of the health care delivery system, social workers and counsellors, and close family members who are important care providers at home. Care basically involves clinical management, nursing care, counselling and social support.

AIDS and NGOs

Q: What role do NGOs play in AIDS control?

A: NGOs have an important and very special role to play. The close interpersonal interaction that NGOs have with people in the communities they work in is extremely useful for implementing the behavioural interventions necessary for HIV/AIDS prevention and care. NGOs are also not under the same political constraints as government programmes are. They therefore have greater flexibility and the capacity to accommodate changing programmes and public needs and can innovate and implement new initiatives more easily.

AIDS and the Workplace

Q: Is it safe to work with someone infected with HIV?

A: Yes. Most workers face no risk of getting the virus while doing their work. If they have the virus themselves, they are not a risk to others during the course of their work.



Q: Why are people safe from HIV infection during work?

A: As explained already, in adults, the virus is mainly transmitted through the transfer of blood or sexual fluids. Since contact with blood or sexual fluids is not part of most people's work, most workers are safe.

Q: What about working every day in close physical contact with an infected person?

A: There are no risks involved. You may share the same telephone with other people in your office or work side by side in a crowded factory with other HIV infected persons, even share the same

cup of tea, but this will not expose you to the risk of contracting the infection. Being in contact with dirt and sweat will also not give you the infection.

Q: Who is at risk while at work?

A: Those who are likely to come into contact with blood that contains the virus are at risk. These include health care workers – doctors, dentists, nurses, laboratory technicians, and a few others. Such workers must take special care against possible contact with infected blood, as for example by using gloves.

Q: If a worker has HIV infection, should he or she be allowed to continue work?

A: Workers with HIV infection who are still healthy should be treated in the same way as any other worker. Those with AIDS or AIDS-related illnesses should be treated in the same way as any other worker who is ill. Infection with HIV is not a reason in itself for termination of employment.

Q: Does an employee infected with the virus have to tell the employer about it?

A: Anyone infected, or thought to be infected, must be protected from discrimination by employers, co-workers, unions or clients. Employees should not be required to inform their employer about their infection. If good information and education about AIDS are available to employees, a climate of understanding may develop in the workplace protecting the rights of the HIV-infected person.

Q: Should an employer test a worker for HIV?

A: Testing for HIV should not be required of workers. Imagine that you are a worker with HIV infection and are healthy and able to work. As far as your work is concerned, the information

about the infection is private. If it is made public, you could be a target for discrimination. If AIDS-related illness makes you unfit for a particular job, you should be treated in the same way as any other employee with a chronic illness. A suitable alternative job can often be arranged by the employer.

Employers in different parts of the world are beginning to deal with these problems more humanely. Their associations and workers' unions can be consulted for advice.

AIDS and Travel

Q: Should a traveller or tourist be concerned about AIDS?

A: Travellers should know about HIV and AIDS because AIDS is a reality throughout the world today. Concern about AIDS, however, should not be an obstacle to travel. Avoiding HIV infection depends mainly on each individual. You can easily protect yourself against HIV infection during your travels by



knowing and following some simple rules – the same rules which protect you in your home surroundings.

Q: Can a traveller become HIV-infected just by casual contact in a foreign country?

A: No. HIV is not transmitted through casual contact or daily routine activities, either at home or in a foreign country. For example, it is not spread by sitting next to someone who is infected, shaking hands, coughing, or sneezing. HIV is not spread by public transportation, public telephones, restaurants, food, cups, glasses, plates, drinking water, air, toilets, swimming pools or insects.

Q: How can a traveller get infected with HIV?

A: In the same way he or she may get infected back home. The virus spreads most frequently through sexual activity, from an infected person to his or her sexual partner. It also spreads through contaminated blood – in transfusions, on needles, or on any other skin-piercing instruments.

Q: How can the sexual spread of HIV be prevented while travelling?

A: By following the same precautions as one would follow in one's own country, even in countries which claim they have no AIDS problem. You cannot tell by appearance if someone is infected with the virus; he or she can look healthy. You can avoid HIV infection by refraining from sex or by practicing safer sex. Safer sex involves the correct use of a condom throughout each sexual encounter. Men should use a condom each time from start to finish, and women should make sure that their partner uses one. Remember that vaginal and anal sex can spread AIDS. Oral sex also poses a risk. Finally, remember that the fewer sexual partners you have, the lower your risk of exposure to the virus that causes AIDS.

Q: What if you are already infected with HIV? Can you still travel?

A: If you are already infected, consult your health care provider for guidance well before you plan to travel. Some immigration officials insist on an HIV free certificate. Your travel counsellor will advise you.

National AIDS Response

**Q: 'AIDS is mainly a problem of developing countries.'
'No, AIDS is really a problem of developed countries'.
Which of these opinions is more accurate?**

A: Many people would like to claim that AIDS only affects others – other people or other countries. AIDS breaks the patterns that we associate with major diseases, for example linking malaria with the tropics or perhaps heart disease with the industrialized world. AIDS affects both developing and industrialized countries, both cold and hot countries. HIV can spread anywhere where people live and have sex.

Q: How do AIDS problems in different countries relate to each other?

A: They are related in at least three ways. First, in every country, AIDS is always spread by a virus transmitted through sexual intercourse and through blood. Specific actions by people are therefore required for it to spread in all countries. Second, AIDS can be stopped in all countries by people changing their sexual behaviour, by screening blood for transfusion, and by sterilizing needles and syringes. Third, the prevention and control of AIDS bring most countries of the world together in joint action. They have the same basic problems to solve. For example, all must test donated blood and everyone must benefit from the availability of simple, reliable and cheap blood tests to detect the virus. Only joint international action can make such tests widely available

and affordable. It is to find these common solutions that the WHO Global Programme on AIDS was established in 1987 and now UNAIDS has been established. Many other groups and organizations are involved as well in what is now a broad partnership between many countries.

Q: How is the AIDS epidemic being handled by countries?

A: Every country in the world is being encouraged by the World Health Organization and the United Nations to organize a national AIDS programme (NAP). Almost all countries have developed national AIDS programmes in collaboration with WHO and, are already implementing them. The first step in this process is to establish a broadly represented national AIDS committee with responsibility for coordinating the NAP, its plans and implementation. It is vital to find out how far HIV infection has spread in the country and then to monitor the epidemic as well as the impact of AIDS prevention activities continuously. Health workers at all levels must be trained to give proper medical care to AIDS patients and accurate information to the public.

The purpose of all activities is very specific:

- to prevent sexual transmission of the disease – through information and education;
- to prevent blood transmission of the disease by making blood safe and ensuring that injection equipment and other skin-piercing instruments are always sterile; and
- to prevent mother-to-infant spread of the virus.

National programmes must also help provide care and social support to those already infected with HIV, including persons with AIDS, as well as to their families.

The UN has been asked by the international community to provide the leadership necessary to shape national efforts into one international strategy for the control of AIDS. This includes attention to health as well as to the socioeconomic and ethical

aspects of AIDS. Everyone involved is learning by doing and by evaluating what has been done.

Q: Where do individuals and communities fit in all of these programmes?

A: This is a challenge in every emergency and in all crisis situations. AIDS programmes are no exception. Individuals and communities have the power, directly or indirectly, to either spread or to stop HIV infection. They are also at the centre of the local, national, and international policies and programmes, and mould the customs and attitudes on which the various AIDS programmes are built. AIDS prevention and care programmes must reach and involve the people. If they do not, the programmes must be changed. People must be helped to protect themselves and others from HIV. Only then will AIDS programmes succeed in preventing the further spread of the virus.

9

Terms Commonly used in AIDS Communication

AIDS The initials AIDS stand for Acquired (A) Immune (I) Deficiency (D) Syndrome (S) – a group of symptoms and signs caused by the Human Immunodeficiency Virus (HIV).

Antigen test A laboratory test done on a sample of a person's blood to detect the presence of parts of the HIV organism itself. The virus is present only in minute amounts and, in addition, cannot be found with this method during many stages of infection.

Azidothymidine (AZT) Also known as zidovudine, retrovir, or 3'-azido-3'-deoxy-thymine. This drug interferes with one of the HIV enzymes (reverse transcriptase) responsible for replication of the virus. The virus cannot multiply quickly, and so damage by the virus to the *immune system* is slowed down. Side effects of the drug include severe anaemia. The long-term effects are not known. Currently it is only used for some of

the people who have already developed AIDS. Because of its side effects, its use requires skilled medical supervision. Current cost of a course of AZT for one person over one year is about US\$10 000.

Asymptomatic HIV-infected person

An HIV-infected person who appears well but is capable of transmitting the infection to another person. Such persons may not have outward signs or symptoms of the infection they carry.

B Cell

A lymphocyte which matures in the bone marrow (hence B-cell), and produces *antibodies*.

Bi-sexual person

An individual who has sexual relations with both males and females.

Blood product

Substances that can be produced from human blood to treat a variety of medical conditions such as haemophilia.

Casual contact (casual sex)

A sexual encounter with another person that does not lead to a long-term relationship.

Casual social contact

This is contact with individuals that is not of a sexual nature.

CD4 count

A measure of the number of CD4 lymphocytes in the blood of HIV-infected persons. This measurement is usually obtained to establish baseline information for a patient before initiating treatment with AZT and thereafter monitoring the course of infection.

Care provider

Any individual or group that provides care for individuals with symptomatic HIV infection in the home or in a health facility.

- Condom** A soft rubber device made of latex which is worn by the male before sexual intercourse begins and during intercourse. The condom prevents sperm from entering the female genital tract and thus prevents pregnancy. The condom also prevents contact with seminal and vaginal fluids thereby preventing the transmission of STD and/or HIV from either partner.
- CSW** Commonly used abbreviation for 'commercial sex worker'. A CSW is an individual, man or woman, who engages in sexual acts for the sole purpose of soliciting payment.
- Combination therapy** A commonly used term to describe the use of more than one drug to treat a medical condition.
- Contact tracing or partner notification** It is a public health measure to interrupt transmission of sexually transmitted infections by finding, interviewing and offering treatment to sexual partners of patients (clients) diagnosed as having sexually transmitted disease (STD). Since many STDs have no symptoms, contacts may be unaware of their infected status and may need education and counselling before they agree to undergo treatment.
- Counselling** A confidential dialogue between a client and a care provider aimed at enabling the client to cope with stress and take personal decisions related to HIV/AIDS. The counselling process involves the evaluation of personal risk of HIV transmission and facilitation of preventive behaviour (see pre- and post-test counselling).
- DNA** Deoxy-ribo-nucleic acid (DNA) is the nuclear protein of cells (genetic material) that forms part of the

chromosomes. It is the chemical in cells that is responsible for 'remembering' all the structures and functions of a cell, and for maintaining that memory in all future generations of cells. When a cell divides, the DNA divides and identical portions are transmitted to both cells. HIV becomes part of the DNA of white blood cells, and so is transmitted to all progeny of those cells.

Comprehensive HIV/AIDS care

The provision of medical and nursing care, counselling and social support services to individuals affected by HIV. These services, when provided, can help meet the needs of most people.

Continuum of care

The provision of comprehensive care from the hospital to the home, which advocates the pooling together of medical and social services within the community and the creation of linkages between community care initiatives at all levels of the health care system.

ELISA

Short for Enzyme-Linked Immuno-Sorbent Assay. A test that is used to detect specific antibodies made in response to infection by different organisms.

Epidemiology

The study of the distribution and determinants of an infection or disease event in a defined population group.

False negative test result

A test which fails to detect antibodies to HIV despite the presence of antibodies. This is very rare indeed.

False positive test

A test which indicates the presence of antibodies to HIV when in fact the person does not have antibodies.

GPA

Global Programme on AIDS (1987 – 1995). The WHO programme formerly responsible for leading

a global effort against HIV/AIDS. Some of the work that GPA carried out continues under a new unit within WHO, the AIDS and STD Division (ASD). This collaborates with the joint UN programme (see UNAIDS).

HIV The abbreviation for human immunodeficiency virus, the virus that can cause to the development of AIDS. This virus was previously known by a variety of names such as LAV and HTLV III. Two types of HIV have been isolated so far: HIV 1 and 2.

Person with HIV A person who, on testing, has been found to have antibodies to HIV. If the test is *truly positive*, then it means the person has been infected with HIV. Most people develop antibodies to HIV between six weeks and three months after infection, but some may take up to six months to develop antibodies. The person may look and feel perfectly well, but is potentially infectious to other people. The test may be a *false positive*, in which case the person does not really have antibodies.

Person testing negative for HIV A person who, on testing, does not have antibodies to HIV, and hence either:

- is not infected,
- has recently been infected but has not yet produced antibodies (window period), or
- was infected some time ago, but is no longer producing antibody.

Home-based care (homecare) The care of persons living with HIV infection and AIDS in their homes. This involves the provision of comprehensive care by community members,

NGOs, Community Based Organizations (CBOs), health workers and family members. This type of care is complementary to the existing health care services.

HIV test Refers to one of the HIV antibody tests. Laboratory tests are performed on a sample of a person's blood to detect the presence or absence of antibodies to HIV. The presence of antibodies in an adult indicates that the person has been infected with the virus. The most commonly used test is the Enzyme-Linked Immunosorbent-Assay (ELISA).

Human rights The basic entitlement accorded to every human being. The rights include the right to health, education, shelter, employment, property, food, freedom of expression and movement.

IEC Information, Education & Communication (IEC), which comprises a range of approaches, activities and outputs to raise awareness about HIV/AIDS for behaviour change.

IDU An abbreviation for 'Intravenous drug use'. This means the practice of using drugs through injection into the veins.

Immune deficiency When a person's immune system is deficient and cannot satisfactorily protect the body, resulting in an increased susceptibility to infection.

Immune suppression When the ability of a person to resist or overcome infection has been severely reduced. This may be due to the intake of certain drugs used for treatment or to frequent infections.

Immune system	The body's defence mechanism against attack by bacteria, viruses, harmful food substances, and some proteins.
Incidence	The number of new cases in a population occurring over a specified period of time.
Incubation period	The time between infection by a disease-causing organism and the onset of signs and symptoms of the disease.
Kaposi's Sarcoma	A rare cancer affecting the walls of blood vessels, which usually appears as pink to purple painless spots on the skin. It is one of the <i>opportunistic infections</i> (it is thought to be caused by a virus) to which people with AIDS are prone. It is uncommon in South-East Asia.
Lymph glands	These are small glands, or nodes, in the body which contain large numbers of <i>white blood cells</i> . Agents of infection are channelled into the lymph system, and so forced to meet the white blood cells in the lymph glands. Infections cause swelling of these glands.
Lymphadenopathy	Swelling of lymph glands, or nodes. Swollen, firm and possibly tender <i>lymph nodes</i> are commonly found in the groin, armpits and neck. The cause may range from an acute (short-lasting) infection like flu to lymphoma (cancer of the lymph nodes) and HIV infection.
Lymphocytes	A class of <i>white blood cell</i> responsible for regulation of the <i>immune system</i> . The cells are divided into <i>B Cells</i> (which produce antibodies) and <i>T Cells</i> (which destroy organisms or infected cells).

Mandatory blood testing	Means HIV testing without consent. This form of testing is useful only for the screening of blood, semen, organs and human tissue for treatment of medical conditions. It must not be used for any other purpose. Mandatory testing has no role in National AIDS programmes.
MSM	An abbreviation for men who have sex with men.
Multi-drug resistant tuberculosis (MDR-TB)	The development of tuberculosis bacillus strains that are resistant to most of the drugs that are commonly used. This often results from improper and injudicious use of drugs.
NAC	An abbreviation for National AIDS Committee. This is the committee responsible for the development of HIV/AIDS policies in a country.
NAP	An abbreviation for National AIDS Programme. This is the operational arm of the NAC, responsible for facilitating and implementing AIDS policies in a country.
Opportunistic infections	Infections that are caused by organisms to which the body is normally immune. When the immune system is depressed or destroyed, as in AIDS, opportunistic infections can take hold.
Partner notification	The contact of an individual who has been exposed to an STD through the partner that attended a health facility.
Pneumocystis carinii pneumonia (PCP)	One of the <i>opportunistic infections</i> seen in immune-suppressed people in developed countries.
Polymerase chain reaction (PCR)	A new technique that can be used to multiply one DNA molecule millions of times so that it can be detected by other tests. This is used to detect the

	HIV virus in a situation when antibodies are not yet developed.
Post-test counselling	Dialogue between a client and a care provider aimed at discussing the HIV test result and providing appropriate information, support and referral, and at encouraging risk reduction behaviours.
Pre-test counselling	Dialogue between a client and a care provider before an HIV test aimed at discussing the HIV test and the possible implications of knowing ones HIV sero-status. This leads to an informed decision as to whether to have the test performed or not.
Protease inhibitor	A class of antiviral agents that disrupt the normal function of an enzyme called HIV protease, preventing HIV replication. Currently available information shows the effectiveness of these agents and hit towards the possibility of the development of a cure in foreseeable future.
Retrovirus	Retroviruses are a class of viruses characterized by their ability to convert RNA to DNA during replication in the host cell (instead of the reverse as in most other viruses). To do this, an enzyme called <i>reverse transcriptase</i> is required. HIV belongs to this group of viruses.
Reverse transcriptase	An enzyme which HIV uses to replicate itself. Much research is being devoted to finding a drug which will inhibit this and thus prevent HIV replication.
RNA	An abbreviation for ribo-nucleic acid, the genetic material inside a cell that is used to make structural and functional components. HIV is an RNA virus.

Safer sex	Sexual practices which reduce the risk of transmitting HIV during sexual activity, e.g. condom use. <i>Unsafe Sex</i> , on the other hand, allows exposure to fluids that can transmit HIV.
Sero-conversion	When an individual who is HIV antibody negative becomes antibody positive after exposure to the virus, i.e. the blood serum has been converted from negative to positive. During this process the person may suffer an acute illness. In the case of HIV infection, the symptoms may be those of flu and/or swollen glands. Sometimes no symptoms are observed.
Sentinel surveillance for HIV/AIDS	Unlinked and anonymous testing of blood for the purpose of monitoring the prevalence and trends in HIV infection over time and place in a given population.
Sexually transmitted disease (STD)	Any disease that is usually acquired while having unprotected sex with an infected partner. Such diseases may also be transmitted by other routes.
Syndrome	A set of symptoms and signs resulting from a single cause, or so commonly occurring together that a definite clinical picture is manifest.
T-helper cells	Also called T4 cells. These are one type of <i>white blood cell</i> or <i>lymphocyte</i> that helps in defending against disease by initiating antibody production. In people with AIDS, T-helper cells are so depleted that the immune system no longer fights off disease and opportunistic infections can occur.
T-suppressor cells	Also called T8 cells. These are another type of lymphocyte or white blood cell. They inhibit antibody production when the infection has been overcome.

T-cell ratio	The proportion of T-helper to T-suppressor cells. In a healthy person, this proportion is approximately 2:1. In an AIDS patient, it drops below 0.5:1 (i.e., it becomes inverted).
Targeted interventions	Programmes or activities targeted to specific population groups in order to achieve specific objectives. For example, increasing the use of condoms among truck drivers in order to reduce STD rates.
Transmission	The spread of infectious <i>agents</i> from one person to another. The predominant mode of HIV transmission is through sexual intercourse.
UNAIDS	This is the Joint United Nations Programme on HIV/AIDS cosponsored by the United Nations Development Programme (UNDP), the United Nations Educational and Scientific Organization (UNESCO), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the World Bank (WB) and the World Health Organization (WHO).
Unlinked anonymous HIV testing	Testing of blood samples for HIV that were originally collected for other purposes after all the information that can identify the source of the blood has been removed. The information gathered is used for surveillance purposes.
Virus	An organism visible only with an electron microscope. Viruses cause a wide variety of diseases in humans, including some cancers.
Virucides	Chemical substances that can kill viruses when inserted inside the vagina. The potential for widespread use is being tested.

- Voluntary testing** Testing initiated either by the client or his or her health care provider and performed with the clients informed consent after pre-test counselling has been provided. The confidentiality of test results should be maintained.
- Western blot** A test used to confirm the presence of HIV antibodies detected by use of the ELISA. This test is no longer recommended (barring exceptions) due to its cost and the fact that two ELISA tests using different principles produce results as accurate as does the western blot test.
- White blood cells** Cells in the blood that are responsible for fighting infectious agents. There are several types of white blood cells including *lymphocytes*.
- Window period** The period of time when a person has been infected with HIV but has not yet produced antibodies. This period is usually no longer than 6 to 12 weeks.

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List of WHO/SEARO Publications on AIDS

Understanding and Living with AIDS, SEARO 1992, 64 pages, gratis.

This document is a SEARO adaptation of 'Living with AIDS in the Community', written and produced in 1991 in Uganda by the AIDS Control Programme, MOH and the AIDS Support Organization, UNICEF and WHO, and revised by GPA and UNICEF in 1992.

This book will help readers to understand how HIV is spread and what people can do to avoid becoming infected. It provides practical information for health and health-related workers and all those involved and interested in understanding AIDS and helping people to live with AIDS in the community.

HIV Testing Policies and Guidelines, SEARO 1994, SP. 16 pages, gratis.

This is reprinted from a paper entitled 'HIV Testing Policies – An Overview' published in the Indian Journal of Medical Research,

Vol.97, November 1993, pp.209-222 by Jai P. Narain, S. Pattanayak and N.K. Shah.

The issues discussed relate to the purpose and appropriateness of HIV testing in the overall context of National AIDS Control Programmes as well as in other settings. In addition, it includes questions and answers on the issue of mandatory testing.

AIDS Prevention: What Maternal and Child Health Service Providers Need to Know, Regional Health Paper, SEARO, No 23, 1992, 43 pages, Rs 60.

This publication is a guide for Maternal and child health/family planning (MCH/FP) service providers and is suitable for adaptation for national use or use by different grades of MCH/FP service providers. By implementing the recommendations given in the booklet, MCH/FP service providers can help in reducing the impact of HIV pandemic.

Carrying Out HIV Sentinel Surveillance - A Guide for Programme Managers, WHO SEARO, April 1994, SEA/AIDS/68, 14 pages, gratis.

Surveillance is an important tool for characterizing the nature and magnitude of an epidemic. HIV surveillance studies are needed to monitor the trends of HIV infection in various population groups - including those considered to be at higher or lower risk. Such data are essential for advocacy as well as planning purposes. This document describes the steps to be taken in establishing an HIV sentinel surveillance system and the use of data so obtained for programme purposes.

HIV/AIDS Care at the Institutional, Community and Home Levels, WHO SEARO, 1993, SEA/AIDS/65, 24 pages.

This is the report of a WHO Regional Workshop on HIV/AIDS Continuum of Care at the Institutional, Community and Home Level, held in Bangkok from 29 March to 2 April 1993. Given the varying and increasing needs created by the AIDS pandemic, and the limited resources, this document underlines the need for integrating AIDS care into primary health care services and the establishment of linkages between hospitals, health centres and communities to provide appropriate and cost-effective care to people with HIV/AIDS.

An Orientation to HIV/AIDS Counselling – A Guide for Trainers, WHO SEARO, 1994, 125 pages, gratis.

This training guide is divided into seven modules which deal with: basic information on STD/HIV; HIV counselling - its nature and purpose; values and attitudes of a good counsellor; effective counselling techniques; sexuality and sensitive issues; pre- and post-testing counselling; and problem-solving counselling. Adaptation could be undertaken in individual countries to meet the local and culture specific counselling needs of persons affected by HIV infection and AIDS as well as their families.

HIV/AIDS in South-East Asia, IXth Meeting of National AIDS Programme Managers, New Delhi, 8-12 November 1993, WHO SEARO, 1994.

National AIDS Programme Managers, having gained considerable experience in fighting the HIV pandemic, meet every year to share their experiences. This report covers the topics discussed by Programme Managers in 1993 and particularly highlights aspects such as effective interventions for HIV/AIDS prevention and care in the countries of South-East Asia.

Information, Education and Communication: A Guide for AIDS Programme Managers, WHO SEARO, 1995, SEA/AIDS/9, 38 pages, gratis.

When planned well, within the context of an overall HIV/AIDS prevention and control programme, IEC can be a very effective intervention to bring about appropriate changes in behaviour, especially among populations with high risk behaviour. IEC is also important for advocacy, to motivate policy and decision-makers to create environments conducive for behavioural changes and to provide the needed services such as condoms, counselling and treatment of sexually transmitted diseases.

This guide has been developed through a regional consultation and presents a framework for IEC within a prevention and control programme for HIV/AIDS. It describes the steps in HIV/AIDS IEC planning and implementation. Although directed primarily to programme managers of national AIDS control programmes, the Guide is also useful for non-governmental organizations and other groups implementing HIV/AIDS IEC activities.

Handbook on AIDS Home Care, WHO SEARO, 1995, SEA/AIDS/87, 304 pages, gratis.

This publication is an adaptation of a WHO headquarters document (AIDS Home Care Handbook). The Asian version was developed following a consultation held in New Delhi and was field tested in four countries: India, Thailand, Indonesia and Myanmar. The handbook provides very useful information on care of patients with HIV/AIDS in the community and at home. The aim is to enable health care workers to help individuals, families and communities to manage AIDS-related problems and build confidence in their ability to provide safe and compassionate AIDS care at home. Besides health care workers, the handbook will be immensely useful to NGOs and people living with HIV/AIDS.

Condom Social Marketing for AIDS/STD Prevention, WHO SEARO, 1995, SEA/AIDS/84, 18 pages, gratis.

This is a report of an intercountry workshop held in Kathmandu, Nepal, from 22 to 25 November 1994. The document contains basic information on the importance of and experience related to condom social marketing in South-East Asia and describes strategies for further strengthening it.

AIDS in South-East Asia: A Pictorial Summary

This is a packet containing a set of 16 posters on HIV/AIDS prevention and care, suitable for display at meetings and at training sessions.

NGOs and Aids: Responding to the Expanding Epidemic, J.P. Narain and A. Jha, 1997, 30 pages, gratis.

This booklet is targetted primarily for the NGOs and provides information on epidemiological aspects of AIDS in South-East Asia and priority strategies and interventions for prevention and care. It also describes areas where NGO have unique role to play and how they can collaborate effectively with national AIDS programmes.

The above publications can be obtained from:

Regional Adviser, STD/AIDS Programme
WHO Regional Office for South-East Asia
World Health House
Indraprastha Estate
Mahatma Gandhi Road
New Delhi 110 002, INDIA
(Fax 91-11-331-8607, Tel. 331-7804 to 331-7823)

